MILITARY CONSTRUCTION AND VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2007

WEDNESDAY, MARCH 29, 2006

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:35 p.m., in room SD–124, Dirksen Senate Office Building, Hon. Kay Bailey Hutchison (chairman) presiding.

Present: Senators Hutchison, Craig, Allard, Feinstein, Johnson, Landrieu and Murray.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. R. JAMES NICHOLSON, SECRETARY

ACCOMPANIED BY:

JONATHAN B. PERLIN, UNDER SECRETARY FOR HEALTH
DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS
WILLIAM F. TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS
TIM S. McCLAIN, GENERAL COUNSEL
ROBERT J. HENKE, ASSISTANT SECRETARY FOR MANAGEMENT

STATEMENT OF SENATOR KAY BAILEY HUTCHISON

Senator HUTCHISON. The subcommittee will come to order. Our hearing today, of course, is to review the fiscal year 2007 budget request for the Department of Veterans Affairs.

I'm very pleased to welcome the Secretary of Veterans Affairs, Jim Nicholson; Under Secretary for Health, Jonathan Perlin; Under Secretary for Benefits, Daniel Cooper; Under Secretary for Memorial Affairs, William Tuerk; General Counsel, Tim McClain; and Assistant Secretary for Management, Robert Henke.

We are facing a time when our servicemen and women are returning from the Global War on Terror in Iraq and Afghanistan, and many of them are coming home wounded. Sometimes it would be a loss of limb, sometimes a brain injury or post-traumatic stress syndrome. The VA will have its hands full for years to care for those who have defended our country.

Mr. Secretary, I want to say that you have demonstrated leadership not only in the war on terror and coming forward last year and saying, "We need more money," working with us to make that happen in the very best possible way. We appreciate that forthrightness that you gave, and also what you did during Hurricanes Katrina and Rita. When we look back on the emergency planning

for the Veterans Affairs, you really did everything right. Under your watch, the VA did not lose a patient, and I saw many of those evacuees, myself, in Houston. And I want to say, especially, thank you to Dr. Perlin for your real creativity not only for the planning for the hurricanes but also the electronic health records, which really made a huge difference for those veterans who were displaced so quickly. They never lost a record. Everybody was ready to treat them, it was seamless. And HealtheVet is a terrific system that you are credited with, and we thank you for that.

Mr. Secretary, I think it's a wonderful news story that the veterans healthcare system is now getting so much good publicity, and the care is renowned to be among the best in the country. And I know that also has caused problems, because now more veterans, who wouldn't have come to the veterans system before, now are coming. So, that is creating a bigger workload.

Certainly, the VA's budget request for this year is $80.6 billion in budget authority for fiscal year 2007, $42 billion is mandatory programs, and discretionary is $38.5 billion. I think this is a good budget. Most of the increases, however, are based on increased collections and savings that rely on enacting legislative proposals that are in your budget request, including an annual enrollment fee of $250, a pharmacy copayment increase to $15 for priority 7 and 8 veterans. And without the proposed legislation, the increase in the medical services budget would be $2.7 billion, or 8.7 percent. So, we want to work with you, but I think you know that the committee is not supportive of the revenue requirements in the budget. So, we want to talk with you, work with you to try to see how we can address these issues, and perhaps look for some other options for revenue.

I also want to mention the Gulf War Illness research, which is certainly a great area of interest to the committee. And I note that your research budget is 3.16 percent below last year's level, so I will want to hear how you plan to do Gulf War Illness research and the other prosthetic research that I know you're also looking at doing with that lower budget.

Last year, the subcommittee directed the VA to consolidate its IT project with procurement, hardware, software, under one organization overseen by the Office of Information Technology. And we would like to have an update on how that reorganization is going. There is also a reduced request for the major construction account, which I hope that you will also be able to address.

So, overall, I think, Mr. Secretary, we have a budget with which we'll be able to work on and we look forward to working with you. And we do appreciate the leadership that you have shown at the Department of Veterans Affairs.

With that, I would like to ask my very wonderful colleague and friend—I started to say my ranking member, but I feel like she's one of our most productive and equal members of our committee. And so, I'll call on my colleague Senator Feinstein.

STATEMENT OF SENATOR DIANNE FEINSTEIN

Senator FEINSTEIN. Thank you very much, Madam Chairman.

And welcome, Mr. Secretary and gentlemen. I wish I could say "ladies and gentlemen." But at least I can say "gentlemen." Welcome.

I sincerely hope this will be a smoother year than last year, and that we do not have the repeat of the shortfalls that we saw last year. As you all well know, California's home to the largest number of veterans in America. And I think Texas is either second or third. Certainly,—second?—and then, I guess, Florida is third. So, this is a major concern to both the chairman and to myself.

While I believe the fiscal year 2007 budget is a good starting point from which to formulate the appropriations bill, I have some concerns in some areas.

The first, and most glaring, are the fee proposals contained in the budget request. This budget assumes savings and fee collections of over $795 million by doubling prescription drug copayments and imposing a $250 enrollment fee on middle-income veterans, many of whom are struggling to make ends meet on incomes as low as $26,903 a year. More than 200,000 veterans would be adversely affected by these proposals. I believe they are unrealistic assumptions. Congress has rejected them in the past. And I, for one, hope we will continue to reject them.

Additionally, I remain concerned by the savings the budget has assumed regarding efficiencies. This year, the President's budget request contains over a billion in anticipated resource savings associated with so-called efficiencies. As you know, last year this subcommittee directed the VA to provide detailed justification for management efficiencies. It remains clear, to this day, what those efficiencies actually are. I understand that this year the VA has termed these savings "clinical efficiencies" rather than "management efficiencies." Mr. Secretary, I hope in your testimony you will shed some light on the difference between these two and exactly how you're going to achieve these efficiencies, or savings, without cutting services.

I'm also very concerned about the special needs of those veterans returning from combat in Iraq and Afghanistan. Roughly 505,000 Iraq and Afghanistan veterans have separated from military service following their tour of combat. The latest figures show the VA having treated over 144,000 of these for a variety of healthcare problems. The VA has estimated that it would treat 110,556 of these veterans in 2006. However, according to VA statistics, through January the VA had already treated almost 75,000. And, at that time, there were still 8 months left to go in the fiscal year. In 2007, the VA is estimated it will treat 109,191 Iraq and Afghanistan veterans. This seems somewhat low, considering the trend that's upward.

Now, I know, Mr. Secretary, these are tough issues, but I hope you'll address them. And, if you don't, we certainly will in our questions. But I want to welcome you, and I want to thank all of you for the service to our country.

Thanks, Madam Chairman.

Senator HUTCHISON. Thank you. In order of arrival—Senator Johnson.

Senator Mitch McConnell has submitted a statement to be entered into the record.

[The statement follows:]

PREPARED STATEMENT OF SENATOR MITCH MCCONNELL

Senator McConnell will continue to work with the Kentucky Congressional delegation to advocate vigorously on behalf of the Commonwealth's veterans.

American bravery and courage have been demonstrated in the heroic efforts of our Nation's veterans since the founding of our country. That rich tradition continues in the stalwart efforts of today's generation of American soldiers. In the continued struggle to rid the world of terrorism, our fighting men and women have time and again demonstrated their willingness to stand guard against the enemy and defend our way of life. This protection has come at a great cost, however, with over 2,600 soldiers having paid the ultimate price for our freedom. Furthermore, many more soldiers have also sacrificed of themselves, and as a result, bear the lasting scars—both physical and mental.

As the nearly 18,000 wounded soldiers who have bravely served our country in Iraq and Afghanistan return home, it is important that they receive the first-rate medical care they need. These soldiers—many from Kentucky—will be dependent on the Department of Veterans Affairs (VA) to provide them with the proper care.

The VA's CARES Stage I Summary Report for Louisville points out that there are over 117,000 enrolled veterans living within the Northern Market of VISN 9—an area that encompasses most of Central and Eastern Kentucky. Unfortunately, the report also details that only 61.6 percent of those enrolled veterans, many living in Kentucky, have a VA primary care facility that is readily accessible to them. This is a full eight percentage points lower than the threshold the VA has deemed acceptable. Given this fact, and that there are nearly 400,000 veterans living in Kentucky, it is troubling that the VA has not requested funding for construction of new veterans' healthcare facilities for any community within the Commonwealth for the next fiscal year.

As we begin to examine the issues facing our Nation's veterans in the upcoming year, I will continue to work with my colleagues from Kentucky here in Congress to advocate vigorously on behalf of the Commonwealth's noble veterans. All of us are interested in ensuring that the VA follows through with its proposals to create several new facilities throughout the State.

STATEMENT OF SENATOR TIM JOHNSON

Senator JOHNSON. Well, thank you, Madam Chairman. Welcome, Secretary Nicholson.

I have just come from South Dakota, where we had an interesting roundtable discussion with returning Afghan and Iraq veterans, with a particular focus on PTSD and other emotional mental health issues, and I look forward to your testimony in that regard.

In order to expedite things this morning, Madam Chairman, I will submit an opening statement for the committee record, and I look forward to the testimony of the Secretary.

[The statement follows:]

PREPARED STATEMENT OF SENATOR TIM JOHNSON

I would like to thank Chairwoman Hutchison and Ranking Member Feinstein for calling today's hearing on the fiscal year 2007 budget for the Veterans Administration (VA). Your continued efforts on behalf of our Nation's veterans are greatly appreciated, and I look forward to working with you both as we move forward with this year's VA budget.

I would also like to thank Secretary Nicholson for appearing before the Subcommittee, and for your willingness to serve. As Secretary of the VA, you have a very difficult job and an incredibly important responsibility to our veterans.

Ensuring that our Nation's veterans receive the benefits they have earned and deserve is one of my most important duties as a Senator, and one I do not take lightly. While the President's fiscal year 2007 budget request is a step in the right direction, I am concerned we will fail to meet our obligations unless additional money is appropriated above the level requested by the President.

Recently, I had the privilege of meeting with a number of veterans in South Dakota who have returned from serving in Iraq and Afghanistan. One young man shared with me the difficulties he has had readjusting to civilian life following his

tour of duty. He was currently attending college in South Dakota after serving in Iraq with the 82nd Airborne, and had been waiting months for an appointment with the VA. He required treatment because he was experiencing stress-related problems following his deployment.

Even though he wasn't able to schedule an appointment in a timely fashion, he wasn't resentful. Rather, I was struck by his positive attitude. Like many soldiers, he was proud of his service in Iraq and thankful for the opportunity to serve his country. In fact, he said it made him a better person.

We are all proud of our men and women in uniform, and we must do all we can to ensure that those returning from combat zones are getting the help they need. In addition to making certain that the VA has adequate funding for mental health services and readjustment counseling, we must also guarantee that the budget is properly funded each fiscal year and not subjected to emergency supplemental appropriations.

As you are well aware, the primary reason for the budget shortfall last year was because the VA underestimated the projected costs of caring for soldiers returning from Iraq and Afghanistan. In my opinion, the funding crisis last summer underscored the necessity of mandatory funding. That is why I introduced S. 331, the Assured Funding for Veterans Health Care Act of 2005. I firmly believe the VA budget cannot be subjected to the whims of discretionary spending, and the only solution to this problem is to support my bipartisan mandatory funding legislation.

In addition to new veterans enrolling in the VA, we must also remember those who have served our country in past conflicts. Often times, these veterans rely upon the VA as their only source of health care. That is why I am deeply concerned by the Bush Administration's continued insistence on implementing annual enrollment fees and increased prescription drug co-payments for our Priority 7 and 8 veterans.

These fees are designed to generate revenue in order to help offset VA expenditures. However, some veterans may be forced to seek health care elsewhere because they cannot afford either the annual enrollment fees or the increased co-payment costs. Rather than relying on budget proposals aimed at driving veterans out of the VA in order to save money, we should focus our efforts on providing adequate funding to ensure all those who have defended our country receive the health care they have earned and deserve.

Without question, we are facing tough budget choices this year. However, if we are serious about our national security, and recruiting the best and brightest to defend our country, we must make honor our commitment to our Nation's veterans.

Once again, thank you Madam Chairwoman for calling today's hearing. I look forward to working with my colleagues on the Subcommittee as we begin consideration of the fiscal year 2007 Military Construction and Veterans' Affairs Appropriations bill.

Senator HUTCHISON. Thank you very much.

Senator Allard.

STATEMENT OF SENATOR WAYNE ALLARD

Senator ALLARD. Madam Chairman, thank you. Thank you specifically for holding this hearing. It's a necessary hearing, because we are in the appropriation process, and I'm looking forward to hearing from the witnesses today before the committee.

And I would like to especially welcome a good friend of mine, and a fellow Coloradoan, the Secretary of the Veterans Administration, Secretary Nicholson. Jim, it's good to see you here, and thank you.

Clearly, this committee has many new challenges before us this year. In addition to the roles of veterans from World War II, Korea, Vietnam, and Desert Storm that the VA already cares for, the number of men and women injured while performing their duties in Iraq and Afghanistan grows daily and will only add continued stress to the Veterans Health Administration. Now, while these needs increase, the United States also faces a challenge in reining in Federal spending and reducing our Federal debt over the next few years. This is a precarious balancing act that must always focus on answering the call for those men and women who have served their country courageously.

And, Mr. Secretary, I just look forward to discussing these issues with you further today.

And, with that, I'd like to, again, reiterate my thanks for appearing in front of us today, and look forward to your testimony.

And thank you, Madam Chairman.

Senator HUTCHISON. Thank you, Senator Allard.

Senator Murray.

STATEMENT OF SENATOR PATTY MURRAY

Senator MURRAY. Thank you very much, Chairman Hutchison and Ranking Member Feinstein, for holding today's hearing. Secretary Nicholson, it's good to see you again before one of our committees.

And I just want to say, before I do my opening statement, that I want to just thank Congressman Lane Evans, who announced his retirement yesterday, for his tremendous service to all veterans. He owes—we all owe him a debt of gratitude for the tremendous job he's done, and we will miss him as a Member of Congress. And I know many people here share that sentiment with me.

Madam Chairman, I do want to start with the good news in this budget proposal. After years of seeing inadequate budgets in a massive shortfall, last year we finally, I think, have a decent budget proposal for VA healthcare from this administration, and I want to commend you, Secretary Nicholson, for the focus you give to the wellness initiatives in your budget.

But, overall, I have to say, I am still very concerned that the President's fiscal year 2007 budget doesn't fix the funding problems and is built around denying care instead of meeting the real needs. It seems to me this budget takes one step forward by providing a good number overall for VA healthcare, but takes two steps backwards in limiting access and not being based on real needs.

This budget plan actually locks the hospital doors to 1.1 million deserving veterans, and will keep another 200,000 veterans from accessing the VA, and that is on top of the 260,000 veterans that were denied access last fiscal year. So, while the bottom-line number looks good, how you get there is troubling.

The Bush administration, as Senator Feinstein mentioned, is imposing new fees and copayments and blocking access for veterans to reach that funding number, and I just think that's wrong.

I know that many times in a budget we rob Peter to pay Paul, but in this case what we're actually doing is denying care to 1.1 million veterans to provide care for others. And, to me, that's just morally wrong. And that is on top of the VA's efforts to cut back on outreach to 25 million veterans, of which only 5 million currently access care.

I'm very concerned about the lack of outreach, that it is keeping many of our veterans who have service-related injuries out of the VA, and it's especially troubling when many of those veterans have illnesses specific to their service, like veterans who suffer from the impacts of Agent Orange or Gulf War syndrome.

We all know that when veterans signed up to serve, they were promised healthcare. There wasn't any asterisk. There was no fine print saying "exclusions apply." We made a promise to every veteran, and we need to keep that for every veteran.

And I'm also very concerned about the other step backward I see, and that this budget is still not based on actual demands so that we can know what we need to see, in terms of numbers, for fiscal 2007. Everyone in this committee remembers what happened last year with the tremendous shortfall, and we could be setting ourselves up again for the same kind of shortfall if we don't have a budget that's based on real numbers. Now, I will recognize that the VA is making progress. And I want to commend Secretary Nicholson for that. He has told us that he's been asking for discharge numbers from the Department of Defense, and, under the law that we passed last year, he is meeting with us quarterly to review those numbers. And I really appreciate that.

But I am concerned that the VA's model still leaves out some very critical factors that will impact a number of veterans. We continue to underestimate the number of veterans from Iraq and Afghanistan. This—the model does not account for the many seniors who are today being steered into the VA when they seek access to the new Medicare drug program. This budget doesn't take into consideration the influx of Vietnam veterans, who are now, as they age, increasing their need to have healthcare and are accessing the VA system for the first time. It doesn't account for all the veterans who are today in this country losing their employer-based healthcare and are, for the first time, turning to the VA for care. And, probably most importantly, the VA may give the VISNs adequate funds to provide care, but then it doesn't budget for various programs that they're mandated to enact, like increased mental health care. VA should take these programmatic efforts into account when they do their budgeting to ensure that we do not face any shortfalls.

So, Madam Chairman, for these reasons, I think we still don't have an accurate model, and that is really disconcerting to me. Like many of my colleagues, I spent the March recess going out, talking to a number of veterans, and I talked to a representative from the Washington State Department of Veterans Affairs who told me that they had just completed a voluntary survey of Guard members in Washington State who recently separated after serving in Iraq and Afghanistan. And of the 5,300 surveys they sent out, 1,700 responded, 370 of them were still unemployed since separation. That is 22 percent of them. And 416 said they were underemployed. That's 46 percent of our Guard members who are unemployed or underemployed. Veterans Service officers have told me about veterans coming back from Iraq and Afghanistan who were able to get an initial appointment with the VA within 1 to 3 months upon their return, but then they had to wait 6 months for a consultation, and another 7 months for surgery. So, it is taking our veterans still today over a year before they're getting the care that they are seeking from the VA.

So, Madam Chairman, I will be looking closely at these numbers and to the Secretary's response today, but our veterans and our VA staff, as I have said many times, deserve to have a budget that is based on real numbers and on real demand, and not on gimmicks and fees that are designed to limit care.

Thank you very much.

Senator HUTCHISON. Thank you, Senator Murray.

Senator Landrieu, did you have an opening statement?

Senator LANDRIEU. Madam Chair, I will submit the statement for the record. I'd like to save my time for some questions on some specific matters. So, thank you very much.

[The statement follows:]

PREPARED STATEMENT OF SENATOR MARY L. LANDRIEU

Madame Chairman, Senator Feinstein, thank you for calling the hearing today to discuss the Veterans Affairs fiscal year 2007 budget submission. I would also like to thank Secretary Nicholson for joining us today and for answering any questions this Subcommittee may have regarding the VA's fiscal year 2007 budget submission.

When Americans put on military uniforms and go to the front line, our Nation makes a long term promise to care for them during their term of service and long after the battle is over. Unfortunately, over the years our government has not kept its promise to our Nation's veterans. Over the past years the Veterans Administration has seen an overwhelming increase in enrollees, while support for medical services and benefits has barely increased—not nearly enough to keep pace with increased need and demand. And, as we all know, some veterans are not allowed to enroll in the VA health care system at all.

Each of us has a responsibility to ensure that the VA health care and benefits system receives full authorized funding, and do so without increasing the out-of-pocket fees paid by veterans. We all have an obligation to the men and women who serve our Nation, and we must ensure that the Veterans Administration receives the support it so desperately needs to meet these goals.

While the VA's fiscal year 2007 request, shows an increase, but there are a number of red flags raised. In particular, a few areas for concern are: the proposed increase in prescription co-payment, establishment of a $250 enrollment fee, mental health, State War Veterans Homes, burial benefits, and blinded veterans care.

As of this month we have more than 17,000 wounded military men and women who have earned Purple Hearts in Operation Iraqi Freedom. Coupled with those who have been wounded in Afghanistan we could see over 21,000 combat wounded by the end of the year. The physical wounds sustained by our soldiers heal, however, there is mounting evidence that demonstrates for many of our veterans, the injuries of war never end.

I would like to commend the VA on setting aside $3.2 billion in the fiscal year 2007 discretionary funding request for mental health care. While today's soldier sees an increased chance of survival due to advances in things such as Kevlar body armor, mental health is not given the proper attention it requires.

Mental health issues largely manifest themselves in the form of Post Traumatic Stress Disorder (PTSD) which touches both the active duty as well as the citizen-soldiers of the National Guard and Reserves. These brave patriots who fought for this country's ideals were raised in communities to which they will return to seek comfort and healing. Because of the silently devastating effects of PTSD, family members, friends, and members of the community may never know the extent of the damage caused by a soldier's experience in the war.

If we are not vigilant and continue to seek solutions at the VA level regarding mental health issues, veterans returning from war will potentially be under siege for the rest of their lives.

My home State of Louisiana is proud to operate and maintain three war veteran's homes in Jackson, Monroe, and Jennings. These homes have been innovative and important to the long term care of many veterans that live in these three distinct parts of the State. In order to preserve the fiscal healthcare of these tenants it is critical that we increase VA per diem payments to State Veterans Homes. VA per diem payments are authorized to cover up to 50 percent of the average daily cost of care, the current rate ($63.40 for skilled nursing care) covers less than 30 percent of that cost. As the number of veterans health care needs increase the Federal Government must meet its responsibility to provide the best resources to our veterans.

The per diem program needs protection from attempts to compromise its future. Congress thwarted an attempt last year by the Administration to severely restrict per diem payments which, if enacted, would have cut per diem payments for up to 70 percent of veterans in State Homes.

There are a range of concerns regarding blinded veterans that include issues like lengthy delays in admissions at Blind Rehabilitation Centers (BRC's) to the expansion of Blind Rehabilitative Outpatient Services (BRO's). Veterans who have lost their vision deserve first class treatment and a commitment by the VA to address the issues which will lighten the heavy burden they will endure for a lifetime.

As with other areas that need improvement, the goal for the VA should be to deliver the highest quality of care in a timely manner. Unfortunately, goals often fall short from 400,000 people in a logjam with claims pending at the Board of Veterans Appeals to blinded veterans waiting an average of close to 19 weeks to enter one of ten BRC's. This rehabilitation is essential to assisting blinded veterans in adjusting to their blindness. We must do better.

Madame Chairman, thank you for you and the ranking member's leadership and I look forward to the remarks from our guest.

STATEMENT OF R. JAMES NICHOLSON

Senator HUTCHISON. Secretary Nicholson, welcome.

Secretary NICHOLSON. Thank you, Madam Chairman, members of the committee. I have a written statement that I would also like to submit to the committee to be entered into the record.

Senator HUTCHISON. Without objection.

Secretary NICHOLSON. You know, as Secretary, it's a great privilege, and responsibility, of course, to lead the Department of Veterans Affairs.

Earlier this year, President Bush announced a landmark budget for the Department of Veterans Affairs, a budget of $80.6 billion. That's truly historic in its scope of service to veterans.

Behind the figures is a great story, one of America's truly good-news stories. And I'd be remiss, I think, if I didn't recount one of the best news stories, and one of the least known, of 2005, although, gratefully, you did mention it, Madam Chairman, and that is the heroic efforts of the VA employees during Hurricanes Katrina and Rita. Not only did our staffs evacuate several hundred patients to other hospitals out of the Gulf Coast area quickly and efficiently, they did so at great personal risk and considerable personal loss. One woman, who is a nurse, caught up with, in a hospital in Houston, where we had relocated many of her patients off of her ward at the New Orleans Hospital, said she could see her house during the 4 days they were in there, before we finally got them evacuated, and all she could see was the roof and the chimney. And she didn't know the disposition of her own family, but she stayed right with her patients, and then relocated with her patients, got on an airplane, actually, and didn't know where she was going to end up. And that was—that's quite typical of scores of VA health caregivers in that great catastrophe.

And, Madam Chairman, the citizens of the great State of Texas opened their hearts, as well, to our veterans that we relocated there, and their health caregivers, welcomed them to cities like Houston and San Antonio in their time of need, and Dallas.

The DeBakey VA Medical Center provided much-needed care and comfort to all of the displaced citizen soldiers moved there, that were affected by the hurricane, and they did so in true Texas style. They were made to feel at home. And we are very grateful to all of those who made that possible.

It's also a fact that the VA knows how to protect our veterans' vital health information against this kind of catastrophic event that swept over the Gulf Coast region. Because veterans healthcare records are electronic, no matter where our New Orleans veterans were eventually relocated, their complete health records were available for them, and for their givers, in an uninterrupted manner.

Following a decade-long healthcare transformation, the VA is now at the forefront of America's healthcare industry. And that's not just a proud Secretary saying that, but, more importantly, it's being said by a host of organizations within and outside of the healthcare community.

Let me mention just a few examples. The Journal of American Medical Association has applauded VA's dedication to patient safety. Since you're sitting down, I will say even the New York Times recently characterized the VA as a model for our Nation. And just recently—I think it was the week before last—the "NBC Nightly News" aired a story on the VA that described our healthcare system as, quote, "the envy of healthcare administrators and a model for healthcare nationwide," end of quote.

Our veterans—these are the people that really count to us, the people that we take care of—they rank our care a full 10 percentage points above their counterparts in the private sector. For the sixth consecutive year, the American Customer Satisfaction Index reports that veterans are more satisfied with their healthcare than any other patients in America.

Because our first-rate, high-quality healthcare—because of that, veterans are coming to us in ever-greater numbers. Fully 7.6 million veterans are now enrolled for our care. And this year we expect to see approximately 5.4 million of them. Last year, we had 55 million patient encounters in our system.

Madam Chairman, President Bush, in his 2007 budget proposal for the Department of Veterans Affairs, is fulfilling his promise to our veterans with a strong budget that respects their service to our country and takes a significant step toward redeeming America's debt for our heroes. The President's total request is for $80.6 billion. This is an increase of 12.2 percent over last year's record amount. It is $8.8 billion above the level of last year. This budget contains the largest dollar increase in discretionary funding for the VA ever requested by a President.

Madam Chairman, our written statement presents a detailed description of the President's proposal for 2007. But I would like to take a few moments to highlight several of the key components of this historic budget.

Let's start with veterans healthcare. During 2007, as I said, we expect to treat approximately 5.4 million patients, including more than 109,000 combat veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom. The 3.8 million veteran patients in priorities 1 through 6 will comprise 72 percent of our total patient population in fiscal year 2007. This will be an increase of 2.1 percent in the number of patients in this core group, and will represent the fourth consecutive year during which those veterans who count on us the most will increase as a percentage of all patients treated.

The President's 2007 budget request includes our funding request for the three medical-care appropriations: $27.5 billion for medical services, including $2.8 billion in collections; $3.2 billion for medical administration; and $3.6 billion for medical facilities. The total proposed budgetary resources of $34.3 billion for the medical-care program represent an increase of 11.3 percent, or $3.5 bil-

lion over the level for last year, and it is 69.1 percent higher than the funding available at the beginning of the Bush administration.

Madam Chairman, I want to emphasize VA's commitment to pursue the Gulf War Illness research through our new $15 million a year research partnership over the next 4 years with the University of Texas Southwestern Medical School. Our Under Secretary for Health, Dr. Jonathan Perlin, will be joining you in Dallas soon, with other members of our staff, to discuss this newest avenue of investigation into what is certainly a pressing healthcare issue, a consistent, persistent, pressing issue for our Gulf War veterans, and for their families.

Madam Chairman, the VA is focused on delivering timely, accurate, and consistent benefits to veterans, and their families, as well. The volume of claims receipts has grown substantially during the last few years, and is now the highest that it's been in 15 years as we received over 788,000 claims during fiscal year—or during calendar year 2005, last year. This trend is expected, most assuredly, to continue. We are projecting the receipt of over 910,000 compensation and pension claims in 2006, and nearly as many in 2007.

One of the key drivers of new claims activity is the increase in size of the Active Duty military force, now including reservists and National Guard members who have been called to Active Duty to support Operation Enduring Freedom and Operation Iraqi Freedom. Another is the aging of our veteran population. This has led to a sizable growth in the number of new claims, and we expect this pattern to continue.

A natural outcome of this increasing claims workload is growth in our mandatory spending accounts, which are growing even faster than VA's discretionary budget. We estimate that mandatory spending will increase by 14.5 percent, to over $42 billion, from an estimated fiscal year 2006 spending level of $36.7 billion.

Regarding burials, our veterans are leaving this life at an ever-increasing pace. In fact, 1,800 a day now pass away. Buglers will play Taps for more than 107,000 veterans in our national cemeteries in 2007. That is a 5.4 percent increase over the 2006 estimate, and 15 percent more than the number of interments in 2005.

The President's 2007 budget request for the VA includes $160.7 million in operations and maintenance funding for the National Cemetery Administration. This represents an increase of $11.1 million, or 7.4 percent, over the estimate for last year.

We will expand access to our burial program by increasing the percent of veterans served by a burial option in a national or State veterans cemetery within 75 miles of their residence, to 83.4 percent in 2007. This is an increase of 6.7 percent over last year. Our plan is for the biggest expansion of the national cemetery system since the Civil war. And we are on track.

PREPARED STATEMENT

Madam Chairman, I started out my testimony by saying that this budget is historic, that this is a landmark proposal of funding unmatched by any previous VA budget ever. And I also said that VA's 235,000 employees are doing a terrific job throughout our country in taking care of our veterans. Veterans don't seek the

spotlight of approval, so, as Secretary of Veterans Affairs, it's my privilege to lead our national applause in grateful thanks for every gift our veterans have given us. This proposed budget for VA is President Bush's appreciation for them, our heroes.

Thank you, Madam Chairman.

[The statement follows:]

PREPARED STATEMENT OF R. JAMES NICHOLSON

Madam Chairman and members of the Committee, good afternoon. I am pleased to be here today to present the President's 2007 budget proposal for the Department of Veterans Affairs (VA). The request totals $80.6 billion—$42.1 billion for entitlement programs and $38.5 billion for discretionary programs. The total request is $8.8 billion, or 12.2 percent, above the level for 2006. This budget contains the largest increase in discretionary funding for VA ever requested by a President.

With the resources requested for VA in the 2007 budget, we will be able to strengthen even further our position as the Nation's leader in delivering accessible, high-quality health care that sets the national benchmark for excellence. Whether compared to other Federal health programs or private health plans, the quality of VA health care is unsurpassed. In addition, this budget will allow the Department to maintain its focus on the timeliness and accuracy of claims processing, and to expand access to national and State veterans' cemeteries.

As an integral component of our 2007 goals, we will continue to work closely with the Department of Defense (DOD) to fulfill our priority that service members' transition from active duty to civilian life is as seamless as possible.

Ensuring a Seamless Transition from Active Military Service to Civilian Life

The President's 2007 budget request provides the resources necessary to help ensure that service members' transition from active duty military status to civilian life is as smooth and seamless as possible. Last year through our aggressive outreach programs, VA conducted nearly 8,200 briefings attended by over 326,000 separating service members and returning Reserve and National Guard members. We will continue to stress the importance of an informed and hassle-free transition for all of our forces coming off of active duty, and their families, and especially for those who have been injured.

If active duty service members, Reservists, and members of the National Guard served in a theater of combat operations, they are eligible for cost-free VA health care and nursing home care for a period of 2 years after their release from active military service provided that the care is for an illness potentially related to their combat service. VA has already facilitated transfers from military medical facilities to VA medical centers several thousand injured service members returning from Operation Enduring Freedom and Operation Iraqi Freedom.

There are many other initiatives underway that are aimed at easing service members' transition from active duty military status to civilian life. Within the last year, VA hired an additional 50 veterans of Operation Enduring Freedom and Operation Iraqi Freedom to enhance outreach services to veterans returning from Afghanistan and Iraq through our Vet Centers. They joined our corps of Vet Center outreach counselors hired earlier by the Department to brief servicemen and women about VA benefits and services available to them and their family members. They also encourage new veterans to use their local Vet Center as a point of entry to VA and its services. Our outreach counselors visit military installations, coordinate with military family assistance centers, and conduct one-on-one interviews with returning veterans and their families.

Last year VA signed a memorandum of agreement with Walter Reed Army Medical Center to give severely injured service members practical help in finding civilian jobs. Under this agreement, VA offers vocational training and temporary jobs at our headquarters in Washington, DC to service members recovering at the Army facility from traumatic injuries.

VA and DOD are working together to establish a cooperative separation exam process so that separating service members only need to have one medical exam that meets both military service separation requirements and VA's disability compensation requirements.

Separating military personnel receive enhanced services through the Benefits Delivery at Discharge (BDD) program. This program enables separating service members to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before, or closely following, their military separation. With the assistance of VA staff stationed at 140 military instal-

lations around the Nation as well as in Korea and Germany, service members can begin the VA disability compensation application process 180 days prior to separation. These applications are now processed at two locations to improve efficiency and the consistency of our claims decisions. In addition, our employees conduct transition assistance briefings in Germany, Italy, Korea, England, Japan, and Spain.

MEDICAL CARE

The President's 2007 request includes total budgetary resources of $34.3 billion for the medical care program, an increase of 11.3 percent (or $3.5 billion) over the level for 2006 and 69.1 percent higher than the funding available at the beginning of the Bush Administration. The 2007 budget reflects the largest dollar increase for VA medical care ever requested by a President and includes our funding request for the three medical care appropriations—medical services ($27.5 billion, including $2.8 billion in collections); medical administration ($3.2 billion); and medical facilities ($3.6 billion).

The cornerstone of our medical care budget is providing care for veterans who need us the most—veterans with service-connected disabilities; those with lower incomes; and veterans with special health care needs. A key element of this effort is to make sure every seriously injured or ill serviceman or woman returning from combat in Operation Enduring Freedom and Operation Iraqi Freedom receives priority consideration and treatment.

Initiatives

The 2007 budget includes two provisions that, if enacted, will be instrumental in helping VA meet our primary goal of providing health care to those who need our medical services the most. The first provision is to implement an annual enrollment fee of $250 and the second is to increase the pharmacy co-payment from $8 to $15 for a 30-day supply of drugs. Both of these provisions apply only to Priority 7 and 8 veterans who have no compensable service-connected disabilities and do have the financial means to contribute modestly to the cost of their care. Priority 7 and 8 veterans typically have other alternatives for addressing their medical care costs, including third-party health insurance coverage and Medicare, and were not eligible to receive VA medical care at all or only on a case-by-case space available basis until 1999 when new authority allowed VA to enroll them in any year that resource levels permitted.

As you know, these two initiatives are not new, and I recognize that Congress has not enacted them in the past. However, we are reintroducing them because I believe they are justifiable, fair, and reasonable policies. They are entirely consistent with the priority health care structure enacted by Congress several years ago, and would more closely align VA's fees and co-payments with other public and private health care plans. The President's budget includes similar, small incremental fee increases for DOD retirees under age 65 in the TRICARE system. The VA fees would allow us to focus our resources on patients who typically do not have other health care options. Furthermore, these two provisions reduce our need for appropriated funds by $765 million as a result of the additional collections they would generate, and a modest reduction in demand.

The 2007 budget also includes a provision to eliminate the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans. Veterans receiving medical care services for treatment of non-service-connected disabilities would receive a bill for their entire co-payment. If enacted, this provision would yield about $30 million in additional collections that could be used to provide further resources for the Department's health care system.

The combined effect of all three provisions reduces our need for appropriated funds by $795 million in 2007. I want to work with your committee and the rest of Congress to gain your support for these proposals.

Workload

During 2007, we expect to treat nearly 5.3 million patients, of which 4.8 million are veterans, including over 100,000 combat veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom. Among the remaining patients we will treat are qualified dependents and survivors eligible for care through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), VA employees receiving preventive occupational immunizations, and patients receiving humanitarian care.

The 3.8 million veteran patients in Priorities 1–6 will comprise 79 percent of our total veteran patient population and 72 percent of our overall total patient population in 2007. This will be an increase of 2.1 percent in the number of patients in

Priorities 1–6 and will represent the fourth consecutive year during which those veterans who count on us the most will increase as a percentage of all patients treated.

We have made significant improvements to the actuarial model that was used to support our 2007 budget request, including development of an enhanced methodology for determining enrollee morbidity and a more detailed analysis of enrollee reliance on VA health care compared to other medical service providers. Also, we have added new data sources, including the Social Security Death Index, which resulted in a more accurate count of enrolled veterans. Finally, we have more accurately assigned veterans into the income-based enrollment priority groups by using data from the 2000 decennial census.

VA continues to take steps to ensure the actuarial model accurately projects the needs of veterans from Operation Enduring Freedom and Operation Iraqi Freedom. However, many unknowns can impact the number and type of services the Department will need to provide these veterans, including the duration of the military action, when these veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have made additional investments in key services, such as mental health, prosthetics, and dental care to ensure we will be able to continue to meet the health care needs of these returning veterans and veterans from other eras seeking more of these same services.

Funding Drivers

There are three key drivers of the additional funding required to meet the demand for VA health care services in 2007:

—inflation;

—expanded utilization of services; and

—greater intensity of services provided.

The impact of the composite rate of inflation within the actuarial model increased our resource requirements for medical care by $1.2 billion, or 3.9 percent. This includes the effect of additional funds needed to meet higher payroll costs as well as the influence of growing costs for supplies, as measured in part by the medical Consumer Price Index.

VA will experience a significant increase in the utilization of health care services in 2007 as a result of four factors. First, overall utilization trends in the U.S. health care industry continue to increase. Veterans who previously came to VA for a single medical appointment now more typically require multiple appointments in many different specialty clinics. And, they return more often for follow-up appointments in any given year. To illustrate, in 2005 we treated about 5.3 million individual patients but had a total of over 58 million outpatient visits. These trends expand VA's per-patient cost of doing business. Second, we expect to see changes in the demographic characteristics of our patient population. Our patients as a group will continue to age, will have lower incomes, and will seek care for more complex medical conditions. These projected changes in the case mix of our patient population will result in greater resource needs. Third, veterans are displaying an increasing level of reliance on VA health care as opposed to using other medical care options they may have available. This increasing reliance on VA medical care is due at least in part to the positive experiences veterans have had with the Department's health care system and is a reflection of our status as the Nation's leader in delivering high-quality care. And fourth, veterans are submitting compensation claims with more, as well as more complex, disabilities claimed. Our Veterans Health Administration does the majority of disability examinations required in order to evaluate these claims. This results in the need for a disability compensation medical examination that is more complex, costly, and time consuming.

General medical practice patterns throughout the Nation have resulted in an increase in the intensity of health care services provided per patient, due to the growing use of diagnostic tests, pharmaceuticals, and other medical services. This rising intensity of care is evidenced in VA's health care system as well. This has contributed to higher quality of care and improved patient outcomes, but it requires additional resources to provide this greater intensity of services.

The combined impact of expanded utilization and greater intensity of services increased our resource requirements for medical care by nearly $1.2 billion.

Quality of Care

VA's standing as the Nation's leader in providing safe, high-quality health care is evident and has been well documented. For example:

—in December 2004 RAND investigators found that VA outperforms all other sectors of American health care across a spectrum of 294 measures of quality in disease prevention and treatment;

—the Department's health care system was featured in the January/February 2005 edition of Washington Monthly in an article titled "The Best Care Anywhere";
—the May 18, 2005, edition of the prestigious Journal of the American Medical Association noted that VA's health care system has ". . . quickly emerged as a bright star in the constellation of safety practice, with system-wide implementation of safe practices, training programs and the establishment of four patient-safety research centers";
—the July 18, 2005, edition of the U.S. News and World Report included a special report on the best hospitals in the country titled "Military Might—Today's VA Hospitals Are Models of Top-Notch Care;" and
—on August 22, 2005, The Washington Post ran a front-page article titled "Revamped Veterans' Health Care Now a Model."

It should be noted that for the 6 consecutive year, VA set the public and private sector benchmark for health care satisfaction based on the American Customer Satisfaction Index survey conducted by the National Quality Research Center at the University of Michigan. VA's inpatient index was 83 compared to 73 for the private sector, and our outpatient index was 80 compared to 75 for the private sector.

These external acknowledgments of the superior quality of VA health care when compared to other public and private health plans reinforce the Department's own findings. We use two primary measures of health care quality—Clinical Practice Guidelines Index and Prevention Index. These measures focus on the degree to which VA follows nationally recognized guidelines and standards of care that medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the Clinical Practice Guidelines Index, an internal accountability measure focusing on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to reach 78 percent in 2007, or a 1 percentage point rise over the 2006 estimate. Similarly, VA's Prevention Index, a set of measures aimed at preventive health care, including immunization, health risk assessments, and cancer screenings, is projected to remain at the estimated 2006 high rate of performance of 88 percent.

Access to Care

With the resources requested for medical care in 2007, the Department will be able to both maintain its current high performance dealing with access to medical care as well as seek ways to continually reduce waiting times for non-urgent care. In 2007 we expect that 93.7 percent of appointments will be scheduled within 30 days of the patient's desired date. For primary care appointments, 96 percent will be scheduled within 30 days of the patient's desired date and for specialty care, 93 percent of all appointments will be scheduled within 30 days of the patient's desired date. No veteran will have to wait for emergency care.

VA is also committed to ensuring that no veteran returning from service in Operation Enduring Freedom and Operation Iraqi Freedom has to wait more than 30 days for a primary care or specialty care appointment.

We have achieved these waiting times efficiencies by developing a number of strategies to reduce waiting times for appointments in primary care and specialty clinics nationwide, to include implementing state-of-the-art appointment scheduling systems, standardizing business processes associated with scheduling practices, and ensuring that clinicians focus on those tasks that only they can perform to optimize the time available for treating patients. To further improve access and timeliness of service, VA will fully implement Advanced Clinic Access nationally, an initiative that promotes the efficient flow of patients. This program optimizes clinical scheduling so that each appointment or inpatient service is most productive. In turn, this reduces unnecessary appointments, allowing for relatively greater workload and increased patient-directed scheduling.

Major Changes in Funding

VA's 2007 request includes over $4.3 billion for long-term care ($229 million more than the 2006 level). I can assure you that the patient and cost projections associated with long-term care have been checked to ensure that they represent our real need in this area. While we aim to expand all types of extended care services, we plan to increase the rate of growth of non-institutional care funding about twice as much as that for institutional care. With an emphasis on community-based and in-home care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes surrounded by their families. During 2007 we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 36,700. This represents a 14.4 percent

increase above the level we expect to reach in 2006 and a 33.7 percent rise over 2005.

The Department's 2007 request includes nearly $3.2 billion ($339 million over the 2006 level) to provide comprehensive mental health services to veterans, including our effort to improve timely access to these services across the country. These additional funds will help ensure that VA continues to realize the aspirations of the President's New Freedom Commission Report as embodied in VA's Mental Health Strategic Plan and to deliver exceptional, accessible mental health care.

The Department will continue to place particular emphasis on providing care to those suffering as a result of their service in Operation Enduring Freedom and Operation Iraqi Freedom from a spectrum of combat stress reactions, ranging from readjustment issues to Post-Traumatic Stress Disorder (PTSD). An example of our firm commitment to provide the best treatment available to help veterans recover from these mental health conditions is our increased outreach to veterans of the Global War on Terror, as well as increased readjustment and PTSD services. This includes the December 2005 designation of three new centers of excellence in Waco (Texas), San Diego (California), and Canandaigua (New York) devoted to advancing the understanding and care of mental health illness.

VA's medical care request includes $1.4 billion ($160 million over the 2006 level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. VA has already provided prosthetics and sensory aids to military personnel who served in Operation Enduring Freedom and Operation Iraqi Freedom and the Department will continue to provide them as needed.

Medical Collections

As a result of improvements in our medical collections processes and the initiatives presented in this budget request, we expect to collect over $2.8 billion in 2007 that will substantially supplement the resources available from appropriated sources. In 2005 we collected just under $1.9 billion. The collections estimate for 2007 is $779 million, or 37.9 percent, above the 2006 estimate. About 70 percent of the projected increase in collections is due to the provisions calling for implementation of a $250 annual enrollment fee, an increase to $15 in the pharmacy co-payment, and elimination of the practice of offsetting VA first-party co-payment debts with collection recoveries from third-party health plans. The remaining 30 percent of the growth in collections will result from continuing improvements in billing and collections.

We have several initiatives underway to strengthen our collections processes. These include:

—the Department is implementing a private-sector-based business model pilot, tailored to our revenue operations, to increase third-party insurance revenue and improve VA's business practices. The pilot Consolidated Patient Account Center will address all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes;

—we are working with Centers for Medicare/Medicaid Services contractors to obtain a Medicare-equivalent remittance advice for veterans who are covered by Medicare and are using VA health care services. This project will result in more accurate payments and better accounting for receivables through use of more reliable data for claims adjudication;

—our Insurance Identification and Verification project is providing VA medical centers with an automated mechanism to obtain veterans' insurance information from health plans that participate in the electronic data exchange;

—we are testing the e-Pharmacy Claims software that provides real-time claims adjudication for outpatient pharmacy claims; and

—VA is implementing the Patient Financial Services System pilot that will increase the accuracy of bills and documentation, reduce operating costs, generate additional revenue, reduce outstanding receivables, and decrease billing times.

MEDICAL RESEARCH

The President's 2007 budget includes $399 million to support VA's medical and prosthetic research program. This amount will fund more than 2,000 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of mental illness ($51 million), aging ($40 million), health services delivery improvement ($36 million), heart disease ($30 million), central nervous system injuries and associated disorders ($29 million), and cancer ($28 million).

The requested funding for the medical and prosthetic research program will position the Department to build upon its long track record of success in conducting re-

search projects that lead to clinically useful interventions that improve veterans' health and quality of life. Examples of some of the recent contributions made by VA research to the advancement of medicine are:

—use of the antidepressant paroxetine decreases symptoms related to Post-Traumatic Stress Disorder and improves memory;
—physical activity and body-weight reduction can significantly cut the risk of developing type II diabetes;
—new links have been discovered between diabetes and Alzheimer's disease; and
—vaccination against varicella-zoster (the same virus that causes chickenpox) decreases the incidence and/or severity of shingles.

In addition to VA appropriations, the Department's researchers compete and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2007. Through a combination of VA resources and funds from outside sources, the total research budget in 2007 will be almost $1.65 billion, or about $17 million more than the 2006 estimate.

GENERAL OPERATING EXPENSES

The Department's 2007 resource request for General Operating Expenses (GOE) is nearly $1.5 billion. It is $131 million, or 9.7 percent, above the 2006 current estimate. Within the 2007 total funding request, $1.168 billion is for the management of the following non-medical benefits administered by the Veterans Benefits Administration (VBA)—disability compensation; pensions; education; housing; vocational rehabilitation and employment; and insurance. This is an increase of $114 million (or 10.8 percent) over the 2006 level. Our request for GOE funding also includes $313 million to support General Administration activities, an increase of $17 million, or 5.7 percent, from the current 2006 estimate.

Compensation and Pensions Workload, Performance, and Staffing

VA is focused on delivering timely and accurate benefits to veterans and their families. Improving the delivery of compensation and pension benefits has become increasingly challenging during the last few years due to a steady and sizeable increase in workload. This growing workload is the result of several factors—more claims are being filed; we are experiencing more direct contact with veterans and service members, particularly those who served in Operation Enduring Freedom and Operation Iraqi Freedom; the complexity of claims is increasing; and more appeals are being filed.

The volume of claims receipts has grown substantially during the last few years and is now the highest it has been in the last 15 years as we received over 788,000 claims in 2005. This trend is expected to continue. We are projecting the receipt of over 910,000 compensation and pension claims in 2006 (which includes over 98,000 claims resulting from the special outreach requirements of recently enacted legislation) and more than 828,000 claims in 2007.

One of the key drivers of new claims activity is the size of the active duty military force. The number of active duty service members as well as Reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom have increased. This has led to a sizeable growth in the number of new claims, and we expect this pattern to persist. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach efforts. Our outreach efforts are critical to the men and women who are entitled to VA benefits and services. We have an obligation to extend our reach as far as possible and to spread the word to veterans about what VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise almost 60 percent of the disability claims receipts each year, and the number of such claims is climbing at a rate of 2 to 3 percent annually. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as diabetes, mental illness, and cardiovascular disease. As these veterans age and their conditions worsen, we experience additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. Since the beginning of 2000, the number of veterans receiving compensation has increased 14 percent, from slightly over 2.3 million to more than 2.6 million. However, the total number of disabilities for which veterans are being compensated has increased 37 percent during this time, from nearly 6.0 million disabilities to 8.2 million disabilities. In addition, we expect to continue to receive a growing number of complex disability claims resulting from Post-Traumatic Stress Disorder, environmental and infectious risks, traumatic brain injuries, complex combat-related injuries, and complications resulting from diabetes. Each claim now takes more time and more resources to adjudicate. Additionally, as the Department re-

ceives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors.

In addition to the growing complexity of compensation and pension claims, there are special outreach requirements that will have a significant impact on our workload and program performance. These outreach requirements will result in nearly 100,000 additional claims. As a result of the increasing volume and complexity of claims, the average number of days to complete compensation and pension claims is now projected to rise from 167 days in 2005 to 185 days in 2006, and to fall slightly to 182 days in 2007. In addition, we anticipate that our pending inventory of disability claims will climb throughout 2006 as we receive new claims, reaching nearly 418,000 by the end of this year. The inventory will fall by 5 percent during 2007 to around 397,000. Despite these significant workload challenges, we remain committed to reaching our strategic goal of processing compensation and pension claims in an average of 125 days.

We will address our ever-growing workload challenges in several ways. First, we will continue to improve our productivity as measured by the number of claims processed per staff member. Second, we will continue to move work among regional offices in order to maximize our resources and enhance our performance. Third, we will simplify and clarify benefit regulations and ensure our claims processing staff has easy access to the manuals and other reference material they need to process claims as efficiently and effectively as possible. And fourth, we will further advance our efforts to improve the consistency and quality of claims processing across regional offices.

Even though we will implement several management improvement practices, we will need additional staffing in order to address our workload challenges in claims processing. Our 2007 budget includes resources to support over 13,100 staff members (including nearly 7,900 staff in direct support of the compensation and pensions programs), or about 170 above the staffing supported by our 2006 budget.

Education and Vocational Rehabilitation and Employment Performance

Key program performance will improve in both the education and vocational rehabilitation and employment programs. The timeliness of processing original education claims will improve by 8 days during the next 2 years, falling from 33 days in 2005 to 25 days in 2007. In addition, the rehabilitation rate for the vocational rehabilitation and employment program will climb to 69 percent in 2007, a gain of 6 percentage points over the 2005 performance level.

Funding for Initiatives

The 2007 request for VBA includes $3.4 million to continue development of comprehensive training and electronic performance support systems. This ongoing initiative provides technical training to compensation and pension staff through a multimedia, multi-method training approach that has a direct impact on the accuracy and consistency of our claims processing.

The 2007 resource request for VBA includes $2.0 million to continue the development of a skills certification instrument for assessing the knowledge base of current and new veterans' service representatives and will also result in a skills certification module for a variety of program staff. This initiative will help identify those employees who need additional training in order to better perform their duties and will allow us to improve our screening process involving applicants for higher-level positions.

NATIONAL CEMETERY ADMINISTRATION

The President's 2007 budget request for VA includes $160.7 million in operations and maintenance funding for the National Cemetery Administration (NCA). This represents an increase of $11.1 million (or 7.4 percent) over the 2006 current estimate. The additional funding will be used to meet the growing workload at existing cemeteries by increasing staffing and augmenting funds for contract maintenance, supplies, and equipment. We expect to perform over 107,000 interments in 2007, or 5.4 percent more than the 2006 estimate and 15.1 percent more than the number of interments in 2005.

Our resource request also has $9.1 million to address gravesite renovations as well as headstone and marker realignment, an increase of $3.6 million from our funding for 2006. These improvements in the appearance of our national cemeteries will help us maintain the cemeteries as shrines dedicated to preserving our Nation's history and honoring veterans' service and sacrifice.

We will expand access to our burial program by increasing the percent of veterans served by a burial option in a national or State veterans cemetery within 75 miles of their residence to 83.8 percent in 2007, which is 6.7 percentage points above the

2005 level. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 97 percent in 2007, or 3 percentage points higher than the 2005 performance level.

CAPITAL (CONSTRUCTION AND GRANTS TO STATES)

The President's 2007 budget request includes $714 million in capital funding for VA. Our request includes $399 million for major construction projects, $198 million for minor construction, $85 million in grants for the construction of State extended care facilities, and $32 million in grants for the construction of State veterans cemeteries.

The 2007 request for construction funding for our medical care program is $457 million—$307 million for major construction and $150 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program to renovate and modernize VA's health care infrastructure and to provide greater access to high-quality care for more veterans. When combined with the $293 million that was enacted in the Hurricane Katrina emergency funding package in late December 2005 to fund a CARES project for a new hospital in Biloxi, Mississippi, the total CARES funding since the 2006 budget totals $750 million and since the 2004 CARES report amounts to nearly $3 billion.

Our major construction request for medical care will fund the continued development of two medical facility projects—$97.5 million to address seismic corrections in Long Beach; and $52.0 million for a new medical facility in Denver. In addition, our request for major construction funding includes $38.2 million to construct a new nursing home care unit and new dietetics space, as well as to improve patient and staff safety by correcting seismic, fire, and life safety deficiencies at American Lake (Washington); $32.5 million for a new spinal cord injury center at Milwaukee; $25.8 million to replace the operating room suite at Columbia (Missouri); and $7.0 million to renovate underutilized vacant space located at the Jefferson Barracks Division campus at St. Louis as well as provide land for expansion at the Jefferson Barracks National Cemetery.

We are also requesting $53.4 million in major construction funding and $25.0 million in minor construction resources to support our burial program. Our request for major construction includes funds for cemetery expansion and improvement at Great Lakes, Michigan ($16.9 million), Dallas/Ft. Worth, Texas ($13.0 million), and Gerald B. H. Solomon, Saratoga, New York ($7.6 million). Our request will also provide $2.3 million in design funds to develop construction documents for gravesite expansion projects at Abraham Lincoln National Cemetery (Illinois) and at Quantico National Cemetery (Virginia). In addition, the major construction request includes $12 million for the development of master plans for six new national cemeteries in areas directed by the National Cemetery Expansion Act of 2003—Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota County, Florida; and southeastern Pennsylvania.

INFORMATION TECHNOLOGY SERVICES

The President's 2007 budget for VA provides $1.257 billion for the non-payroll costs associated with information technology (IT) projects across the Department. This is $43.2 million, or 3.6 percent, above our 2006 budget.

The 2007 request for IT services includes $832 million for our medical care program, $55 million for our benefits programs, $4 million for our burial program, and $366 million for projects managed by our staff offices, most notably non-payroll costs in our Office of Information and Technology and Office of Management to support department-wide initiatives and operations.

The most critical IT project for our medical care program is the continued operation and improvement of the Department's electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. Within this overall initiative, we are requesting $51.0 million for ongoing development and implementation of HealtheVet-VistA (Veterans Health Information Systems and Technology Architecture) which will incorporate new technology, new or reengineered applications, and data standardization to continue improving veterans' health care. This system will make use of standards that will enhance the sharing of data within VA as well as with other Federal agencies and public and private sector organizations. Health data will be stored in a veteran-centric format replacing the current facility-centric system. The standardized health information can be easily shared between facilities, making patients' electronic health records available to all those providing health care to veterans.

Until HealtheVet-VistA is operational, we need to maintain the VistA legacy system. This system will remain operational as new applications are developed and implemented. This approach will mitigate transition and migration risks associated with the move to the new architecture. Our budget provides $188 million in 2007 for the VistA legacy system.

In support of the Department's education program, our 2007 request includes $3 million in non-payroll costs to continue the development of The Education Expert System. This will replace the existing benefit payment system with one that will allow the Department to automatically process education claims received electronically.

VA's 2007 request provides $57.4 million for cyber security. This ongoing initiative involves the development, deployment, and maintenance of a set of enterprise-wide security controls to better secure our IT architecture in support of all of the Department's program operations.

SUMMARY

In summary, Madam Chairman, the $80.6 billion the President is requesting for VA in 2007 will provide the resources necessary for the Department to:

—provide timely, high-quality health care to nearly 5.3 million patients, including 4.8 million veteran patients of which 79 percent are among those who need us the most—those with service-connected disabilities, lower incomes, or special health care needs;

—address the large growth in the number of claims for compensation and pension benefits; and

—increase access to our burial program by ensuring that nearly 84 percent of veterans will be served by a burial option in a national or State veterans cemetery within 75 miles of their residence.

I look forward to working with the members of this committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world.

Senator HUTCHISON. Thank you very much. We appreciate that testimony.

MEDICAL AND PROSTHETIC RESEARCH

And I would like to ask you a question, with my time, on the research budget, the area that we discussed, and you addressed, the Gulf War syndrome research, but the other area would be the "smart limb" technology, prosthetics, and other research efforts. And I just wanted to get a read from you on how that is progressing and what other priorities you see. I so appreciate your commitment to Gulf War, because I think we can do so much, not only for the veterans who have symptoms, but for prevention for future potential chemical warfare that might have a causal connection. But on the area of prosthetics, and then what other priorities do you see with your research budget? And are you okay with that slight decrease?

Secretary NICHOLSON. I'll answer the last part first by saying, yes, we have—in the last two budget cycles, have had significant increase in research for prosthetics and for mental health and post-traumatic stress disorder. In the area of prosthetics, I think you mentioned "smart limbs" or C-limbs, we call the legs, the below-the-knee prosthetic now, which is a phenomenal device made of microprocessors that somehow has figured out how to think like the other leg and function accordingly. It's just astonishing. It's a product of research and compassion.

I visit Walter Reed, in Bethesda, regularly, and, every Friday night that I can, I get together, my wife and I, for dinner with the wounded folks that are ambulatory enough to go to a restaurant that—we meet in here, and they are—they are just amazing. And

the work that's being done for them is amazing, as well. And our commitment to the—you know, to the research, both in its—it's both clinical and practical, because we have the opportunity to monitor them, these new returnees, so closely—is—I think it's just—it's world class.

As to the specific details that inquiries of chemicals and so forth, I'll defer to Dr. Perlin and ask him if he would flesh that out with more detail.

Dr. PERLIN. Thank you, Mr. Secretary, and thank you, Madam Chairman.

The research that's being done in VA is truly spectacular. The Secretary mentioned things like the C-leg, but one of the products I'm most excited about is the artificial retina. I'm sure this committee has heard about the cochlear implant that was developed for hearing for people with loss of the outer ear, but with the nerves intact. Two of our sites have really brought the retinal implant to fruition. It's actually being tested in some patients, and, we believe that—for some individuals, it will be able to do things as exciting as restoring vision.

In the area of combat-related research, we will actually conduct over $160 million of activity in things ranging from acute and traumatic injury to sensory loss, military occupational exposures, bioterrorism, and pathogens, brain disorders, and brain injury. And as the Secretary mentioned, on top of that our prosthetics program for the delivery of these devices actually increases to $1.4 billion, an increase of $160 million, 2006 to 2007.

POST-TRAUMATIC STRESS SYNDROME

Senator HUTCHISON. In my remaining time, would you just elaborate a little bit on your post-traumatic stress syndrome, the centers of excellence, progress on that. Is it making a difference, putting caregivers with that expertise into one facility that can be a regional magnet? I'd just like to have a progress report on that.

Secretary NICHOLSON. The short answer is, yes, indeed. We now have put a certified post-traumatic stress disorder, PTSD expert at each one of our 154 medical centers so that we have at least one in each of our centers. We have positioned others in some of our vet centers and in some clinics. Because we're forward-looking, we're—we want to outreach to these young people who are coming back, and even be suggestive that if they're experiencing any of these symptoms, that they should come in and see us, and see one of these experts, because what they are experiencing is a common reaction to the uncommon experience they've just been through, and that if we can begin to treat them early enough, there's a great probability of success and recovery from any long-term effects of this. And we also are doing a considerable amount of research, that's being funded generously by you all, at our National PTSD Research Center, which is in White River Junction, Vermont.

Senator HUTCHISON. Thank you very much.

Senator Feinstein.

PROPOSED LEGISLATION ON FEES AND COPAYMENTS

Senator FEINSTEIN. Thank you very much, Madam Chairman.

Mr. Secretary, let me take on the issue of fees. As you know, last year Senator Burns moved an amendment on the floor which actually received a vote, a unanimous vote, to reject the fee proposal. And you've put it back again this year. The $250 annual enrollment fee, a doubling of the pharmaceutical copayments, eliminating the practice of offsetting or reducing copayments with collections recovered through third-party insurers. How many veterans does the VA estimate will be affected by this policy? These are, I guess, the priority 7 and 8 veterans.

Secretary NICHOLSON. I think the number, Senator, would be approximately 200,000. I think it's 198,000.

Senator FEINSTEIN. Okay. That's both priority 7s and 8s.

Secretary NICHOLSON. Yes.

Senator FEINSTEIN. Is that correct? Okay.

Secretary NICHOLSON. And we also know, about them, that about 95 percent of them have insurance. But I think that——

Senator FEINSTEIN. In those—these are people that make under $26,000 a year, and you're saying——

Secretary NICHOLSON. Not all of them. Some of them might. It depends on where they live.

If I might, I would sort of frame it. Because I happen to personally believe in this. And I'm not just being a good soldier, putting this in the budget. I think that there's a real equity in this. And, you know, they—by the way, the people that enter into the armed services are never told they're going to have lifetime healthcare. The people who are told they're going to have lifetime healthcare, and who were told that, are those that stay in a career. And those that stay in for a career, maybe 30 years, and do two or three combat tours, when they come out of the military, they get TRICARE, which is a program with which they're quite pleased. And I was involved in that in another way at another job, getting that. It's a good benefit. But they have a copay and enrollment fee, which is significantly higher than this, that we are asking for, for veterans, only for categories 7 and 8, which are veterans that have had no service-connected disabilities and who have jobs, and they have served 2 years——

Senator FEINSTEIN. Okay. But let me talk to you about the real world. This was last year, the Burns amendment. It passed 100 to nothing. This is an election year. Somebody is sure to make the same amendment again. You're going to lose—if that happens, what is the total amount that you would lose? Is it $795——

Secretary NICHOLSON. $795.

Senator FEINSTEIN [continuing]. Million dollars. What would your plan be, then, if you lose $795 million? I mean, I think you've been forewarned. That happens, 100 to zero. Pretty good warning that somebody's going to try it again. And the opportunity for it passing is certainly very high.

Secretary NICHOLSON. I wouldn't argue with that, Senator, but I—that doesn't mean that it's not the right and equitable thing to do. But I will tell you, the question is a good one, about the $795 million, because that's important, because we—that is assumed in this budget. And if we do not get those policy proposals, we would need—we will need that money, to do what we think we have to do in this budget year.

Senator FEINSTEIN. So, what would you do?

Secretary NICHOLSON. Well, what we would do is ask you to—if you don't approve that, to increase the appropriation by that amount.

Senator FEINSTEIN. Okay. Has the VA worked with the Defense Department to run any kind of actuarial modeling to determine the impact of these fees on VA patient loads?

Secretary NICHOLSON. I think the answer is, no, we've not worked with the Defense Department, but we've certainly worked with our own actuaries to see what——

Senator FEINSTEIN. Because the——

Secretary NICHOLSON [continuing]. The effect of——

Senator FEINSTEIN [continuing]. DOD is also requesting these fees on the DOD healthcare system.

Secretary NICHOLSON. Yes.

Senator FEINSTEIN. So, I would—so, no modeling has been done to show what the effect of that is.

Secretary NICHOLSON. Well, they're two separate systems. And——

Senator FEINSTEIN. Understand that.

Secretary NICHOLSON [continuing]. We have——

Senator FEINSTEIN. But you're one government, theoretically.

Secretary NICHOLSON. We have not. I think we have not. But we've certainly modeled it ourself to know what it—the patient impact would be.

Senator FEINSTEIN. Okay. I have another question. I see the light is on. Perhaps we could have a second round.

Thank you——

Senator HUTCHISON. Yes, we will——

Senator FEINSTEIN [continuing]. Madam Chairman.

Senator HUTCHISON [continuing]. We will have a second round.

Senator Allard.

Senator ALLARD. Thank you, Madam Chairman.

ROCKY MOUNTAIN REGION COLORADO

The hospital plans for the Rocky Mountain region, for veterans I want to address that a little bit. The Fitzsimons Hospital there in Denver—and it was designed some 50 years ago, and obviously a lot of what people envisioned for healthcare then, and what we're getting now, is lot of needs in the hospital simply can't be met with an older facility. And so, you are moving ahead with the Rocky Mountain facility. And I truly appreciate that. My question is, how are you moving forward with that particular facility? And how does it fit into the Capital Assessment Realignment for Enhanced Services, commonly known as the CARES plan?

Secretary NICHOLSON. Well, thank you, Senator Allard. The CARES plan is the predicate for the determination that there is a need for a new hospital in Denver. And that takes into account current projected patient loads and capacity to serve. And we are moving forward with that. We are moving forward. We are—need to build a new hospital in Orlando, in Las Vegas, in Denver. And we have a recent agreement with the authority that has control over the land at the old—the Fitzsimons Army General Hospital. We've agreed to a site and a price, and we are in stages of seeking ap-

proval for getting the money authorized to acquire the land. And the planning—the site planning and space planning for the hospital is ongoing. So, it's moving—it's moving well, but we now need to acquire the land here——

Senator ALLARD. And the——

Secretary NICHOLSON [continuing]. Shortly.

Senator ALLARD [continuing]. Authorization language, that would come out of the Veterans Committee itself. And you're working on that.

Secretary NICHOLSON. Yes, we are working on it.

Senator ALLARD. And then, I notice that the President also has in his budget here some money to begin to finance the new facility there in Denver.

Secretary NICHOLSON. Yes. And that's——

Senator ALLARD. And——

Secretary NICHOLSON [continuing]. And that's——

Senator ALLARD. So, right now you don't see any real hitches. I mean, things are—seem to be moving along pretty good at this point?

Secretary NICHOLSON. Yes, they do.

Senator ALLARD. Okay. That's good news. And thank you for that effort.

NATIONAL CEMETERY ADMINISTRATION

The other question I have to—has to deal with cemeteries. How is it that we establish whether an area needs cemeteries—or is appropriate to put a cemetery in that area? How do we determine that?

Secretary NICHOLSON. I have Under Secretary Tuerk here with me, who is responsible for Memorial Affairs. And I'll let him give you the detail. Essentially, there are criteria which set out a goal for the VA to have a cemetery within 75 miles of 90 percent of the veterans in our country. And as I said in my testimony, we are in the greatest expansion of cemeteries since the Civil War, because our veterans are aging, and they're passing on at a pretty rapid rate. We need to be there. And there is another criteria of distance, and I'll ask Secretary Tuerk if he'd like to address that.

Senator ALLARD. Mr. Tuerk.

Mr. TUERK. Yes, Senator. Generally speaking, we look at a given site and determine whether there is a national or State cemetery option available in proximity to that site, defined by 75 miles away. That number is based on our own internal studies of the distance beyond which veterans tend not to view a cemetery as a practical alternative.

Over the years, using that 75-mile criterion, we have identified cities and locations and ranked them according to the number of veterans who are unserved. For example, starting back in 1987, Chicago was at——

Senator ALLARD. Yeah.

Mr. TUERK [continuing]. The top of the list, with——

Senator ALLARD. Now——

Mr. TUERK [continuing]. A million——

Senator ALLARD [continuing]. Let me get down to specifics, as my time's about ready to run out here.

Mr. TUERK. Okay.

Senator ALLARD. There is a population number that goes into that—those statistics that you look at, isn't correct?

Mr. TUERK. Correct, Senator.

Senator ALLARD. And my information is that this—they're—they go back quite a distance. What is it? Clear back to the 2000 Census.

Mr. TUERK. As we have come down the list of——

Senator ALLARD. Or do they go back to the 1990 Census?

Mr. TUERK. They are based on the 2000 Census.

Senator ALLARD. Census, okay.

Mr. TUERK. And we have come down the list, and the most recent newly-mandated cemeteries—we had come down to the point where we're selecting cities that had veteran populations of about 170,000 that didn't have a cemetery in proximity.

Senator ALLARD. Yeah. That—you know, I've—some areas of the country, they really had a—not only have they had a rapid growth in the population there, but the veteran population has probably increased even more. And then, on top of the—because of the war, and then also because of their aging and just the fact the demographics of people are moving into the area—and so, if you have an area that, say, is maybe on the borderline in change, is there a mechanism in there, or do you have to wait til the next Census before that whole area gets reevaluated?

Secretary NICHOLSON. You know, I think the answer, Senator Allard, is, absent a showing of some kind of an exponential growth spurt or something, we would have to wait for the next Census, yes.

Mr. TUERK. And I'm advised, Senator, that we do have actuaries retained who try to estimate population changes between the Censuses every 10 years, but they're not precise numbers.

Senator ALLARD. I would just like to solicit your cooperation in, kind of, working with this formula. We've got one of those areas in Colorado Springs.

Mr. TUERK. I would also mention, Senator, that the formula itself, if it can be properly called that, is not set in stone. And, as a matter of fact, we are undergoing a program evaluation right now to examine the underlying assumptions of that formula and see if it's an appropriate way to proceed henceforth.

Senator ALLARD. Well, yeah, I would just ask that Secretary Nicholson, and maybe you, Mr. Tuerk, would just kind of work with us a little bit and just see where we are. We've got somebody that's going to donate land, and there's a huge growing population in there. And, looking from the Census, it's probably grown a little bit. I need to kind of work with the Veterans Affairs to see where you stand on that proposal, and all I need from you is a commitment to, kind of, work with us a little bit on that, and work with that formula, and see if there's a potential need there that—for a cemetery, that perhaps qualifies, that we've somehow or the other ignored.

Mr. TUERK. I'm happy to do that, Senator.

Senator HUTCHISON. Senator Murray.

VA HEALTHCARE

Senator MURRAY. Mr. Secretary, I just—I want to clarify a response that you gave to Senator Feinstein. Are you saying that VA military recruiters are not using VA healthcare as a recruiting tool?

Secretary NICHOLSON. No, I didn't say that. I said that there is no undertaking in the law to provide a recruit for a lifetime of VA healthcare——

Senator MURRAY. Right. Well, it's my understanding that healthcare is the number one tool that recruiters are using today, in terms of veterans having healthcare. Is that not accurate?

Secretary NICHOLSON. I don't—I couldn't—I couldn't tell you whether it is or not. I——

Senator MURRAY. Well, I would just submit to this committee that most of our soldiers who are serving in Iraq and Afghanistan are under the assumption, having been told by a recruiter that they would get healthcare, that, indeed, they would get healthcare. So——

Secretary NICHOLSON. Well, every member of the Armed Forces who serves in the combat zone is eligible for VA healthcare.

Senator MURRAY. That's correct. And they are not told anytime by a recruiter that they are going to be based on what income they have when they return.

Secretary NICHOLSON. They—it shouldn't be, because they're eligible for it, for——

Senator MURRAY. Right.

Secretary NICHOLSON [continuing]. For 24 months, the——

Senator MURRAY. Because I misunderstood what you said to Senator Feinstein, then, because I thought you said that soldiers were not——

Senator HUTCHISON. He did. He said they're not required to provide it for a lifetime.

Secretary NICHOLSON. Right.

Senator MURRAY. Right. But they are being told by recruiters that healthcare is part of what they will get for their service. So, I think——

Secretary NICHOLSON. Well, I don't know what the recruiters are telling them. If they're injured—if they're injured in their service, they would be provided——

Senator MURRAY. Right. I understand that. But——

Secretary NICHOLSON [continuing]. Healthcare.

Senator MURRAY [continuing]. I would just say that we—if we were not going to guarantee them healthcare, we'd better tell our recruiters to say something else.

VA BUDGET MODEL

But, anyway, what I really wanted to ask you about was the model that you have for the 2007 budget. We went through a tremendous challenge last year, as you will recall. Have you changed the model for how you project how much money will be needed by the VA?

Secretary NICHOLSON. The answer, Senator Murray, is that, no, we haven't changed the model. We used the same modeling con-

sultant, but we've certainly supplemented it and looked outside of it in a—you know, in a subjective way with looking—more inputs and more intuitive elements. But the basic model is the same.

And I'll ask Dr. Perlin if he wants to expand on that, because he is——

Senator MURRAY. Well, what I'd really like to know is why you don't base the budget on demand.

Secretary NICHOLSON. Well, of course, we do base it on demand. What we're trying to do is project what the demand will be.

Senator MURRAY. And you're using the same model as you had before we had a war in Iraq and Afghanistan?

Secretary NICHOLSON. Yes. But if you'll remember my testimony of last year, when I—that we were working on the 2005 budget, it was based on 2002 data. And in 2002 there was no war. That's just a victim of our cycling times. We're working 2007 right now, and this—the 2007 data is based on—you know, on 2004 numbers.

Senator MURRAY. Well, I just remain sincerely concerned that the—what we—the demands on the VA today are dramatically different than they were 5 years ago, on OIF and OEF soldiers returning, on increasing number of Vietnam veterans who are accessing it, on the increased cost of healthcare overall, on the fact that many people are losing healthcare and going into the VA that weren't, necessarily, before. Why are we not changing the model so that we don't end up in shortfall come next July or August here?

Secretary NICHOLSON. Well, we use the best predictive tools that are available. That is the model that we use. It's used by almost all the major healthcare providers and integrated systems. It's—and then we've supplemented it by some of our own unique offerings, like long-term care and dental, and so forth. But it is a dynamic field. I would tell you that. And it is growing. But let me say that the patient loads are increasing considerably, but as to the combat, the OIF/OEF, we—you know, we see about 5.4 million people a year right now; and, of that number, about 110,000 to 120,000 are those combatants. That's about 2 percent of——

Senator MURRAY. Are they——

Secretary NICHOLSON [continuing]. That total.

Senator MURRAY. How many OIF and OEF veterans have you budgeted for this year?

Secretary NICHOLSON. For 2007, 109,000.

Senator MURRAY. How many did you see in the first half of 2006?

Secretary NICHOLSON. Which is about to end—we will have seen, I think, 85,000.

Senator MURRAY. How many did you expect to see in 2007, which you based your budget on?

Secretary NICHOLSON. 109,000.

Senator MURRAY. So, in the first half of the year, you saw 85,000, and you're budgeting a whole year on 109,000?

Secretary NICHOLSON. Budget next year on 109,000, yes.

Senator HUTCHISON. Did you—you're—I'm not sure I understand. Are you saying that there were 85,000 just in half a year?

Senator FEINSTEIN. Yes, that's right.

Senator HUTCHISON. I don't think that's what you——

Senator MURRAY. Well, let—you saw 85,000 in 6 months. Your whole budget for 2007, you said, is—you're basing it a hundred-and-——

Secretary NICHOLSON. Nine.

Senator MURRAY [continuing]. 109. I do not——

Senator HUTCHISON. Well, wait a minute, let me go back and then ask—What was the full year, the year before?

Secretary NICHOLSON. Last year?

Senator MURRAY. Last year.

Senator HUTCHISON. Yes.

Secretary NICHOLSON. It was about—it was, like, at 119,800.

Senator MURRAY. And we're looking at 2007, and the budget is based on less than that, 109,000. That's my point. I'm very concerned about that, obviously.

Senator HUTCHISON. Well, let's let him answer why that would be.

Secretary NICHOLSON. Yeah, sure. Dr. Perlin will.

Dr. PERLIN. Thank you, Senator Murray. Your question makes logical sense, but I want to make sure that we distinguish the cumulative number of patients we've been from the annual number. Indeed, the 2007 budget budgets for about 109,000, and 2006 will see—we project about 110,000. And we're running about 38 percent ahead. I should explain two things. First—and something that we're really very proud of is that we have much better hand-in-glove relationship with the Department of Defense that is reaching out to returning combat veterans, something I think we all want. And that has increased. And that gets to the model. The base of the model predicts about 25 percent of the OIF/OEF veteran utilization. The remainder is the experience in reality. Because, as the Secretary said, the model, of necessity, is based on experience of a couple of years back, we don't want to put all of our eggs in that one basket and ever suffer a repeat of not coming up to the right numbers.

Senator MURRAY. But from what I can see is that you are basing 2007 on less numbers than you saw in 2006. What you're asking for, for funding, is based less, yet we know that there are more soldiers returning, more accessing the VA, and more coming. So, I just have a serious concern about the reality of the numbers that we're going to see——

Dr. PERLIN. I think——

Senator MURRAY [continuing]. Based on your budget.

Dr. PERLIN. I think, certainly, this is one of the things that we will discuss during our quarterly meetings, are discussing now, that it's running slightly ahead. I should say that is line with that. We are actually running below the projected expenses. So, in point of fact, the budget is——

Senator MURRAY. Well, and——

Dr. PERLIN [continuing]. Completely robust——

Senator MURRAY. I know you——

Senator HUTCHISON. No, I——

Senator MURRAY [continuing]. I've used my time——

Senator HUTCHISON. No, I want to go ahead——

Senator MURRAY [continuing]. But they're asking——

Senator HUTCHISON [continuing]. And finish this thought, because it—I just am not——

Senator MURRAY. We're asking our——

Senator HUTCHISON [continuing]. I think there's a disconnect.

Senator MURRAY [continuing]. To do more, in terms of Gulf War syndrome and reaching out, and we're seeing more veterans, but we're being asked to fund them at less. So, I'm—I just think we have a real problem with what we're seeing requested here.

Senator HUTCHISON. I think the—there's an increase in the amount, but you are saying that you expect to see fewer patients——

Senator MURRAY. Than we will——

Senator HUTCHISON [continuing]. This year that we're talking about, 2007——

Senator MURRAY. The budget is based on that, that's what——

Senator HUTCHISON [continuing]. Than what you are going to have in 2006. And I don't think that's what you mean, or else there's an explanation that's not there.

Secretary NICHOLSON. Let me try to clarify. The—you're talking OIF/OEF returnees. And, as I said, that's about 2 percent of our total projected patient load. In total patients, we are predicting to see an increase. In——

Senator MURRAY. That's because Vietnam veterans are aging. It's because a number of people are accessing the VA system for other reasons.

Secretary NICHOLSON. Right.

Senator MURRAY. So, that doesn't surprise me. And that's good. But for OIF/OEF, you are projecting we will see less than last year. I'm very worried that is not going to be reality. And I doubt that's what you're going to see.

Secretary NICHOLSON. We're—we are projecting that we'll see about 11,000 fewer than we saw last year. That is, in 2007, we'll see that, fewer than 2006.

Senator MURRAY. And I think that's——

Senator HUTCHISON. What do you base that on, I think is the question? Is it because you have had the major part of the injuries or——

Secretary NICHOLSON. Well——

Senator HUTCHISON [continuing]. There some—must be some——

Secretary NICHOLSON. It's a question of the cumulative versus new patients, and the uniques.

I'll ask Dr. Perlin if he can explain that.

Dr. PERLIN. Thanks. I think it's important, as was mentioned at the beginning, there are about half a million veterans who have separated, having served in combat in OIF/OEF. And, thus far, about 144,500 have come to VA since the inception. And so, I think we should put that number aside for a moment.

Not all of those veterans will come back for return service, because, by and large, most veterans, fortunately, are younger and healthier. There will be some that will carry forward. And so, the way the projection goes is, it's based on how many veterans will come forward from previous years and how many new OIF veterans will come into the system.

I think you are absolutely correct that there are, at this point in the year, more veterans than we had initially anticipated. And I make this point, because this is part of Department of Defense's going out and not only doing post-deployment health assessment, but a reassessment. We're tracking that number. We are well within budget. And, as the Secretary says,—because these are obviously extremely significant veterans and all veterans are significant, we place particular attention here. The overall budget cares for 98 percent other veterans. And we are absolutely within the resources, not only as budgeted for this population, but as budgeted for the entire population, as well.

Senator MURRAY. Well, Madam Chairman, I have other questions, but we'll get back to them.

Senator HUTCHISON. Okay, we certainly will.

Senator Landrieu.

NEW ORLEANS REPLACEMENT HOSPITAL

Senator LANDRIEU. Thank you, Madam Chair.

My question is specific to the supplemental that was just passed by the House, Mr. Secretary, that included the $550 million for the new hospital, which, at our agreement, was taken out of the previous supplemental and put on hold until we could do a little bit more groundwork on standing up the medical complex in New Orleans after Katrina and Rita. And I think we're making some progress on that. And I know you all have been working very closely with Secretary Leavitt and—as we try to develop a new system there.

But the House inserted $275 million that could be taken out of this account for, I guess, quote, "unanticipated medical costs of returning veterans fighting global war on terror." Do you support that inclusion of $275 million? Does the administration support that?

Secretary NICHOLSON. We did not ask for that, Senator, no.

Senator LANDRIEU. Is it your intention to use any of that $550 million for the new hospital with this line item?

Secretary NICHOLSON. No. We currently do not plan to have to use any of that for operational purposes, no.

Senator LANDRIEU. Now, let me be clear. Is it your intention to use any of this $550 million, which is earmarked, at your request, for the hospital to use for the $275 million that the House added into this supplemental?

Secretary NICHOLSON. No. The answer is, no, we do not.

Senator LANDRIEU. Okay.

Secretary NICHOLSON. Which is another way of saying that we plan to use the $550 million plus the $75 million for the hospital.

Senator LANDRIEU. For the purposes in which we have basically all agreed we need to move forward——

Secretary NICHOLSON. Right.

MENTAL HEALTH

Senator LANDRIEU [continuing]. And only postponed it last time because we agreed with you that it wasn't—it's critical, but it wasn't critical 3 months ago. It's critical now, as we only have—just for reference of this committee, I just learned, today, we only

have—let me get these—I'll get the numbers; I don't want to give the wrong ones—but of the 3,000 beds we had open pre-Katrina—hospital beds—I think we only have 400 open in the whole metropolitan area, of a city that had 3,000 hospital beds, of which this hospital is, of course, closed down. We need to stand it up. So, it's quite urgent, in terms of healthcare for this whole region.

Let me ask something on mental health. I understand this is the first year that we've earmarked in the budget, in discretionary budget, something specific for mental health, or is that not true? Is it $2.2 million for mental health? It's not the first time?

Secretary NICHOLSON. It wouldn't be the first time.

Senator LANDRIEU. It wouldn't be the first time?

Secretary NICHOLSON. No.

Senator LANDRIEU. But we have a slight increase for mental health?

Secretary NICHOLSON. We have, I think, $3.2 billion in the——

Senator LANDRIEU. $3.2 billion.

Secretary NICHOLSON [continuing]. Budget for mental health.

Senator LANDRIEU. Okay. I want to commend you for trying to push these numbers slightly higher for mental health. It's been something that many of us on the committee have worked on. What concerns me is part of the GAO report that was just recently issued about the lack of assessment teams at the hospitals that will actually make the determination as to who might be eligible for these services. I understand that we only piloted three programs last year—one in California, one in Texas, and one in New York. So, is there money in this budget to establish the assessment teams so that we can make the proper assessments for these veterans to give them the mental health counseling that has become so obvious?

Secretary NICHOLSON. Well, they're—absolutely. That's one of the reasons that, you know, we've—asking for $3.2 billion, which is an increase of $339 million. And, as I stated earlier, Senator, we have, in every one of our 156 major medical centers, like—New Orleans would be one of those—was—we have a PTSD expert that we've posted in each of these to head those teams for assessment. And we have a very comprehensive assessment——

Senator LANDRIEU. But according to the report, that there are only three complete teams, and then a coordinator, is that not true?

Secretary NICHOLSON. That is not true. I gather that you—that you—there may be confusion, because you mentioned California and New York and Texas. What has happened is that the Congress, you all, in the last few months, have designated three locations to be centers of excellence——

Senator LANDRIEU. Okay.

Secretary NICHOLSON [continuing]. For mental healthcare. Those are Canandaigua, New York; Waco; Texas, and San Diego, California.

Senator LANDRIEU. To coordinate the efforts nationally——

Secretary NICHOLSON. But those——

Senator LANDRIEU [continuing]. For these——

Secretary NICHOLSON [continuing]. Those will just be supplemental to a vast system now.

GRANTS FOR STATE EXTENDED CARE

Senator LANDRIEU. Okay. And one final, on the VA nursing homes, we have a total of $85 million nationally in the budget.

Secretary NICHOLSON. Yes, I think that's correct. Yes, ma'am.

Senator LANDRIEU. The budget was $104 million, last year? And there's earmarked a fairly large center in California. What is the total amount of that money, and how will it affect the building of the other centers around the country?

Secretary NICHOLSON. I'm going to ask Dr. Perlin to respond to that particular area you've asked.

Senator FEINSTEIN. Don't think of taking it from California.

Dr. PERLIN. Well, first, thank you very much for the question. Let me confirm, as the Secretary said, the budget is $85 million, asked for in the 2007 budget. California is a large project, unequivocally. We have a few mandates in front of us. First, we also have to pay attention to life safety. And we will fund those. In fact, there is conference language that asked that we do that. And we have not released the ultimate 2007 decision, in terms of priorities. But, obviously, we've already set aside funding for the California project very substantially—in fact, $68.2 million—in 2006. And we are working with California to make sure that we can, obviously, complete the project in which we both have mutual interests, and meet needs elsewhere in the country, including not just new projects, but also life safety.

Senator LANDRIEU. And I want to say that I most certainly support it, and I'm sure that the Senator who's given great leadership to this committee, could justify every penny for this project. I just raise it that there's a whole country out there of other veterans' homes that are long on the waiting list. And to limit the budget to only that, and also try to accommodate a large project like this, I think, is a disservice to the rest of the country.

So, I'm going to—my time is up, but let me also just say, for the record, I'm going to submit a suggestion on the ratios of how these can be funded in a little bit fairer system than having every State to have to come up with a match, regardless of the economic need of the community.

Thank you.

Senator FEINSTEIN. The chairman went down to vote. She's coming back. And then I'll go. But you're up. So, why don't you go ahead?

Senator CRAIG [presiding]. Thank you very much, Madam Chairman.

Let me submit my full statement for the record and deal with a couple of questions that I think are legitimate. And some of them go back to what Senator Murray was discussing earlier, as it relates to how we get the record straight.

[The statement follows:]

PREPARED STATEMENT OF SENATOR LARRY CRAIG

Thank you Madame Chair. My comments will be brief. Mr. Secretary, good afternoon and welcome. You and I have already spoken at some length about your budget proposal in my capacity as Chairman of your authorizing Committee. First, I want to compliment you and the President once again for making veterans one of the highest priorities in your budget. This historic request of nearly $80 billion demonstrates this Nation's commitment to our veterans.

As you know, I supported your budget request in my "views and estimates" letter to the Budget Committee this year. As you also know, my authorizing Committee only has to comment on your budget. This Committee, on the other hand, has the responsibility of balancing your request against all of the other needs of the Federal Government. Mr. Secretary, quite frankly, that balancing act is becoming increasingly difficult.

If this Committee follows the recommendations set forth in the budget resolution we've just passed, including the Burns amendment, we will provide VA's health care system with a 12.4 percent increase in direct appropriations. That would mean that since 2001, VA's health care budget has increased by nearly 70 percent.

I know we all strongly support our veterans, especially in a time of war. The care of our veterans is not a partisan issue. But, this Committee is the place where the "rhetoric meets the road." If we do not make some serious decisions about VA's health care spending rates, its budget will double every 6 years and will eventually collide with all other areas of Federal spending—things like agriculture, parks, and education. That is not a disputable fact. It's a mathematical reality.

I know many of you on this Committee are not prepared to begin charging certain veterans or increasing the copayments many of them already pay for medications. I understand that. But, I strongly believe that the time is coming for us to take the necessary steps to properly manage VA's health care system even if that means charging $21 per month for certain veterans to access the system.

I say to my colleagues: we are charged with the oversight and funding of what is now considered to be one of the Nation's best health care systems. It is a system of first choice, not one of last resort. Today's veterans enjoy good access to high quality medical care. Now we have a responsibility to ensure that its financial footing is sound and sustainable so that tomorrow's veterans will also receive the benefits of VA's enormous success.

Those management decisions will not be easy. Good management rarely is easy. But, failure to make the decisions will be even harder on tomorrow's veterans than it is on us today. I am prepared to talk or work with any of you on ways to address this issue. In my capacity as Chairman of the authorizing committee, I have already challenged our VSOs to work with me. What I am not prepared to do is ignore this issue and simply pass it on to the next guy. The challenge is too real and the consequences too serious.

Mr. Secretary, thank you again for being here. Thank you Madame Chair.

Senator CRAIG. And I know Louisiana and California feed over money, but right now——

Senator FEINSTEIN. Well, I made it pretty clear.

Senator CRAIG. She's got to understand who runs this committee. No.

OIF/OEF VETERANS

During the floor debate in the Senate budget resolution, I heard many of my colleagues express concerns about certain facts. It has reemerged again today as it relates to OIF and OEF veterans and numbers coming in. And I think it's important that we get the record as clear as we can in light of this historic budget. And it is a historic budget in size and scope. You are comfortable with the 2 percent figure at this moment as it relates to veterans coming into the system out of these two conflicts.

Secretary NICHOLSON. Yes, sir, we are. The size of the force over there is also somewhat diminished. And so, we're comfortable, based on the experience that we've had, yes.

Senator CRAIG. More importantly, the funds that VA has budgeted for in OIF and OEF veterans in this fiscal year, how do you—how do actual expenditures compare with what VA budgeted for thus far?

Secretary NICHOLSON. They are running less, by about 34 percent, than we had budgeted for this category of patients.

Senator CRAIG. So, in light of where the money seems to be headed at this moment, based on your projections, you feel you're on target.

Secretary NICHOLSON. Yes, I do. We're, I think, in good shape. We are seeing somewhat more at this point, the halfway point in the year, but our costs are less. So, we think that we will be able to see—care for those that we see.

Senator CRAIG. And this also includes the outreach that DOD is currently doing.

Secretary NICHOLSON. Yes, sir.

Senator CRAIG. Could you explain the distinction between the cumulative number of OIF and OEF veterans who have been treated at the VA since budget assumes will seek treatment in the current year—the current fiscal year of 2007?

Secretary NICHOLSON. Yes. Because we see—let's say, in the beginning, we—you know, we see *X* number, and then in the next year, or the next measuring unit, we would see *Y*. But some of *Y* are made up of those that we had already seen. So, in terms of unique patients—that is, individual patients—it would be different.

Senator CRAIG. Okay. Madam Chairman, I have some additional questions I want to ask. Are you prepared to recess, and we'll run and vote and come back?

Senator FEINSTEIN. I thought—the chairman's going to come back. But I thought I'd go down. And that way, we'd just keep it going.

Senator CRAIG. All right.

Senator FEINSTEIN. We'll do a second round.

Senator CRAIG. Okay.

Senator FEINSTEIN. But if you're not finished, and would like to do more, I can run and vote, and—well, you have to vote, too.

Senator CRAIG. Well, why don't you go ahead, and I'll stay here until the—until the chairman gets back. And if I find I'm at risk, I'll recess it until she gets here.

Senator FEINSTEIN. All right, excellent.

Senator CRAIG. Thank you.

Senator FEINSTEIN. I will go, because I don't want to miss you. We've got to talk reprogramming the money, which I know you'll be delighted about.

QUARTERLY REPORTING TO CONGRESS

Senator CRAIG. I think, for the record, it's also important to establish, based on, I think, the frustration of those on the authorizing committee and the appropriating subcommittee here, had in light of the past fiscal environment and the shortfalls that became obvious, at our request, and your urgence, we have established a quarterly reporting system so that we can effectively monitor both outlays and anticipations of movement beyond where the budget was established. We've had that—we've had the first quarter report, and those will continue.

Would you wish to comment on that as it relates to that process, the modeling process, and, frankly, a new tracking mechanism that you've incorporated that includes those kinds of outputs to us?

Secretary NICHOLSON. Yes, Senator. Yes, Senator, I would. I welcome the chance to comment on that, because, as I've said earlier,

this is a dynamic arena that we are in, with a war going on and a large number of patients and potential patients for this large system. So, we are very glad that we've gone to a quarterly reporting system with you, the oversight people, the Congress. With OMB, we're doing it monthly. And we've instituted that. So, to do that monthly, we have, you know, an almost daily tracking system, from a management point of view. So, we have a—we have a much better feel for what is going on at any given time than we've had in the past. And if we see not just red lights, but yellow lights, we plan to be as fully transparent as possible with you all about this, and the fact that we may need your help to help the veterans.

Senator CRAIG. Well, I think that's important, that the record show that, from that which some have a reason to be concerned and have—and are making judgments to where we are today, it is significantly different than how we have operated in the past, and, I think, appropriately so, as we deal with a dynamic process and the potential that that might change in relation to conflict and activities and the outreach programs the DOD is working in, in relation to that 24-month window in which those coming out of Iraq and Afghanistan have opportunity of services beyond what might be connected to actual injury or problems arising from their service in the theater.

For the sake of me not missing a vote, or prolonging it, I'm going to recess the subcommittee for a few moments. The chairman will return, and I will return, also. So, the subcommittee will stand in recess.

INFORMATION TECHNOLOGY SYSTEMS CONSOLIDATION

Senator HUTCHISON [presiding]. I want to reconvene the hearing. There were two, and possibly three Senators who do plan to come back for a second round. But I wanted to ask if you could give me an update on the IT consolidation.

Secretary NICHOLSON. Yes, I can, Madam Chairman. By way of background, we've done a spectacular job at the VA—and I say "we," it's really the people who proceeded me; we're sitting on their shoulders—and, you know, our electronic medical records, it's a phenomenal achievement. But now we need to bring the rest of the information technology of the VA into the 21st century. And it's a very spread-out system. It covers this Nation—Hawaii, Alaska, Philippines, Guam. And there are a lot—there have been a lot of individual kinds of systems and applications out there, which is very inefficient, very expensive, and not effective.

And so, we hired a very prestigious consultant to come in and look at that, and make a set of recommendations to us. And they have done that. And we have chosen to implement essentially what they recommended, which is to centralize the IT in this big bureau. And that is underway. I've signed the implementing documents to do that. It involves the transference of thousands of people in the Department from where they have been into the governance of the chief information officer, the Assistant Secretary for IT.

Senator HUTCHISON. Have you been able to see any results yet, or is it just premature to see if there are savings or efficiencies?

Secretary NICHOLSON. Well, it's just—it has just begun.

Senator HUTCHISON. Just begun.

Secretary NICHOLSON. Uh-huh.

RIO GRANDE VALLEY, TEXAS

Senator HUTCHISON. I wanted to ask you something on a parochial level. The veterans in South Texas, as you know, have been very concerned about their lack of a hospital there, and a major clinic. You have, I think, come out with a terrific proposal for a clinic in conjunction with a medical facility that I think is going to be—it sounds, by the description, like it's going to be a wonderful service for our veterans. But then, on the subject of the hospital, I had had a recommendation from a city council member that there was a facility that had been closed that should be suitable for a hospital. And you agreed to look into it. Has there been any result from that yet, or is that still in progress, as well?

Secretary NICHOLSON. That is in progress. What I agreed to was to do a study, an assessment of the needs in that Rio Grande——

Senator HUTCHISON. Valley.

Secretary NICHOLSON [continuing]. Valley area to, number one, try to assess what the populations of veterans were, what their needs are, and what we have there available to serve them, and what is possible that we could add. But that is an——

Senator HUTCHISON. In progress.

Secretary NICHOLSON [continuing]. Ongoing progress, yes.

Senator HUTCHISON. Well, that's what I asked for. And then I did make the suggestion, which is in your office, of just looking at this facility. I haven't seen it myself, so I'm not saying it's appropriate, but if it is something that would be feasible and lower cost and be more efficient, and if the population warrants it in your priority list. Today, they have to travel several hundred miles from that lower Rio Grande Valley to San Antonio VAMC to Audie Murphy VAMC, if they are going to need day surgery or day care, but some of it would be overnight, as well. So, I would just look forward to hearing about that.

The other area was your major construction account, which is also somewhat reduced. And I just wanted to ask what your thinking was on being able to justify a reduction in the major construction account.

Secretary NICHOLSON. Well, we have, as I mentioned, several ongoing projects, big projects. You know, the VA has not built a hospital—not opened a new hospital now, I think, in 13 years, but we need to some new hospitals, and we're ongoing in that process. But you can't spend all the money at one time. And so, while we're going forward with Las Vegas and going forward with Orlando, they really didn't need a lot of money in the 2007 budget. So, we have in there the other projects. We have several that need seismic repair. They're—it's just one of those things, doesn't add much value to—it's like putting new plumbing in your house, but you have to do it, if it's needed. And, in this case, we have some properties that are subject to earthquake vulnerabilities, and we're having to spend, as you can see there, considerably amount of money for seismic. And so, it—you know, it's a matter of those felt safety needs versus some of the projects that needed some money to keep them moving in this process.

Senator HUTCHISON. Are you looking, in the next 5 years, at a 5-year plan for new hospitals, where you do see significant needs? Is that part of your assessment, both for the Rio Grande Valley, but for other places?

Secretary NICHOLSON. Yes. In fact, the CARES process, which is a major comprehensive assessment to the capital assets of the agency, versus projected populations, projected out to, I think, the year 2012, and we have that data, and that's been the basis for the decisions for new hospitals, in the case of those that I've mentioned.

Senator HUTCHISON. And, of course, I know that I'm—I'm dealing right now with the supplemental, and we have a major commitment for New Orleans. And then there will be a major commitment for the Armed Forces Retirement Home in Gulfport and then a major commitment in Biloxi for facilities, as well. So, I suppose that those are going to be coming into the regular budget after they are built and able to operate.

Secretary NICHOLSON. Well, for operating, the—indeed, they will. But New Orleans is in a supplemental——

Senator HUTCHISON. Right.

Secretary NICHOLSON [continuing]. Mode at—I think right now we have requested $600 million and $75 million has previously been appropriated.

Senator HUTCHISON. Right.

Secretary NICHOLSON [continuing]. It's only 8 miles away.

Senator HUTCHISON. Right. And that is going to be more a regional center, as I understand it.

Secretary NICHOLSON. Yes.

Senator HUTCHISON. We're working right now on the supplemental for what we can do with that—the land there at Gulfport. I think we have a good solution for compensating the Veterans Affairs for that land.

Secretary NICHOLSON. At Gulfport?

Senator HUTCHISON. Yes.

Secretary NICHOLSON. Uh-huh, yes.

Senator HUTCHISON. Yes.

CLAIMS PROCESSING

Can you give us an update on the progress the VA is making on reducing the backlog of benefit evaluations?

Secretary NICHOLSON. Yes. I'll give you a—you know, kind of the big picture. Then I'm going to ask Under Secretary Cooper to, if he would, give you the detail.

But we are hiring new people, and training them, in the effort to bring down the backlog. I just visited a—one of our major regional offices in St. Paul last week. They're hiring and training. There is a training gap with these people. It takes about 15 months to really qualify a claims adjudicator, you know, to do this, and do it carefully and accurately.

And, with that, I'd ask Admiral Cooper if he'd have anything to add.

Admiral COOPER. Yes. We're attempting to attack that every way we possibly can. We are hiring more people, and we're going to do centralized training to ensure that we get them trained properly to

do the same thing across the country at 57 different regional offices. So, training is one of the main things.

We're looking at some consolidation. We have a program called Benefit Delivery at Discharge, which is for those people coming out of the service at the end of their careers, and we have consolidated that activity at two sites—one in Winston-Salem, North Carolina, and other in Salt Lake City—so that those two regional offices are doing those particular claims and, therefore, hopefully doing them better and eventually a little bit faster.

We do a lot of brokering. We try to look at those regional offices which have a little bit more capacity. And as soon as a claim is ready to rate, we broker it to those offices, so we don't have an issue of not having enough people to rate the claim at a specific site.

So, we're doing a lot of moving around. Primarily, however, it is through training and hiring that we hope to eventually succeed.

The major problem, however, is that we can do a lot for output, but incoming is something we can't control. And as long as the incoming keeps increasing, then we're sort of fighting against it. But eventually we will get there.

Senator HUTCHISON. Senator Craig.

Senator CRAIG. Thank you very much, Madam Chairman.

VA BUDGET

Let me make a few comments, and then I have one last question. I'll stay within our time limits here that are—I think are important to make, because what I think I have said, and others have said, and I think it's important that the record show, that under this precedent we are looking at a historic request of nearly $80 billion for veterans in this country. That is a phenomenal prioritizing of resource, and it demonstrates, without any question, in my opinion, the commitment of this administration.

I also want to tell you that I've had a bite at this apple prior to this subcommittee getting it. As chairman of the authorizing committee, I have the responsibility of doing views and estimates in a letter to the Budget Committee for the purpose of establishing the level of funding that we will deal with here, and that you in this committee must allocate. And, in doing so, I think it is important to understand that we have a problem growing here that we chose not to face this year on the floor. And I think the Senator from California, in part, touched it when she talked about the Burns amendment, stepping back from the fees for 7s and 8s, and also the pharmaceutical fee.

Here's the reality, though. This is a 12.4 percent increase over last year. And I think it's important to understand that. That means that, since 2001, VA healthcare budgets have increased by 70 percent. That's also to suggest that if we continue this trend, VA budgets will double every 6 years. And I must tell this committee, that is not a sustainable course. No matter how much we want for our States, or expect, or try to find and get unique services, we cannot sustain by continuing to ask at the level we're asking unless we ask something different.

So, I chose this year to accept the administration's approach, and to suggest that 7s and 8s, who have no connection, in the sense

that they are service-connected or disabled—and, as you've already heard the Secretary say, of which many of them already have healthcare—to pay less than a carton of cigarettes a month to have access to the best healthcare system in the country. And every VSO said no. And the Congress said no.

Well, what the Congress is failing to recognize is that they cannot sustain what they're doing. And we have to change that. And I'm willing now to stand up and speak out and say it's time to change. I accept what we've done. I accept what this committee's been handed. And we will monitor and try to act as wisely as we can. But we have a phenomenal collision on course at this moment, because we are dealing, as I think we all recognize, with largely discretionary funding that collides with everything else we want to do. And mathematically the reality at hand is the reality of great complication.

I've challenged all of the VSOs to work with me in the coming year, because there was a time not long ago when they accepted exactly what they rejected this year. And what we have to look at are a variety of different approaches, I think, to find revenue sources, the some $790 million that we decided not to fund through these kind of new revenues. And, therefore, because we decided not to fund them, and by funding them, 199,000, or somewhere near that, of that large number would have dropped off from the 7s and 8s, because they have alternative healthcare. That would have changed the real value of this—of revenue in the reality of savings over—to well over $800 million.

Well, we've chosen not to do that, so it's real dollars. It isn't the $795 million that we would have gained by the new revenue sources. It's actually over $800 million. I say that. I think it's important that it be said for the record. It is my opinion. And I will speak it as loudly as I can, recognizing that my priority is to serve veterans, and the priority of this committee and the Congress is to serve veterans, is to suggest that we must find a sound and sustainable course of funding for VA, not just for today's veterans, but for tomorrow's veterans, in a very real problem that we have out there.

And I'm going to fight awfully hard over the course of the next 12 months as to our—the priorities we establish and how they get funded, because there is a reality that I think can—that all of us can withstand the test of. Those who are in need, those who deserve treatment, are being treated, and they're being treated by the best healthcare system in the world. And we've extended, to 24 months out, for those coming out of Iraq and Afghanistan, services that heretofore they had not had unless they were directly connected to a theater of a war and a disability involved. It's important that, I think, we say that.

Now, in saying that, let me ask this question. Mr. Secretary, in my analysis of, and your feedback, over the period of the last several months as we've looked at this budget in dealing with 7 and 8 priority veterans, and anticipating that by the action of raising a monthly fee so that they could gain access, or be eligible for access, that there would have been a certain number who would have left, simply stepped back from it, because they had alternative

forms of healthcare, they would choose not to pay the $21 a month. Is that correct?

Secretary NICHOLSON. That's correct, Senator.

Senator CRAIG. And we believe that was about how many?

Secretary NICHOLSON. About, I think, 199,000—200,000.

Senator CRAIG. And it is an—it is believed, based on your surveys, that 95 percent of those had healthcare, and that's why they would have stepped back.

Secretary NICHOLSON. Yes, sir.

Senator CRAIG. And so, the reality of the $790 million raised by both pharmaceuticals and prescription drug copay and also the fee would have been $790 million, but this loss, in total benefit to the budget, would have been over $800 million. Is that not correct?

Secretary NICHOLSON. $795 million is the amount.

Senator CRAIG. In new revenue.

Secretary NICHOLSON. No. It's the——

Senator CRAIG. Oh——

Secretary NICHOLSON [continuing] Combination.

Senator CRAIG [continuing]. Combination of, okay.

Secretary NICHOLSON. Revenue plus——

Senator CRAIG. I wanted to make sure I—I was dancing off the top of my head in memory, and I wasn't quite sure. So, 795.

Secretary NICHOLSON. $795 million.

Senator CRAIG. $795 million.

Well, Madam Chairman and Ranking Member, that's a reality check. And that's why I say what I say, because we're going to squeeze these budgets, and squeeze them hard, to maximize service to our veterans. At the same time, we are on an unsustainable course. I do believe that. Because I think the three of us will be presiding over $100 billion budget to the VA in a very short time, and certainly within our tenure, at the current rate.

And my suggestion to you is that you're going to have a budget chairman at some point in time tell this committee that that money simply is no longer available at that level of increase.

Thank you, Madam Chairman.

Senator HUTCHISON. Thank you, Senator Craig.

I appreciate what you have said. It is—it's a tough situation. And I am working with my staff on some potential alternatives, that are not this one, but maybe other things, that wouldn't hit a $28,000 level of annual income. But I would look forward to working with you, Senator Feinstein, with the VA, to see if there are other options besides the ones that are envisioned in the bill that might be acceptable to the VSOs and the committee, as well.

Senator CRAIG. Well, Madam Chairman, thank you. I know that you and I have had those discussions. I really appreciate that kind of thinking, because I think to continue to serve at the level of service we want to provide for our veterans, we're going to have to become creative in looking at a variety of approaches to resolve this issue.

Thank you.

Senator HUTCHISON. Senator Feinstein.

Senator FEINSTEIN. Thank you very much, Madam Chairman.

And I think, Senator Craig, what you've said is both wise and sobering. The question is really whether somebody on the floor comes

up with something, whether there are enough lemmings that are going to follow along. And—oh, I'm—shouldn't have said that word.

But I'm really concerned, because we have a lot of wounded, and we have a lot of people now that are going to be using veterans services for a long, long time, and many with, you know, terrible injuries. And so, we have to be ready for it.

MEDICAL SERVICES REPROGRAMMING

And I'm concerned with the planning model used, Mr. Secretary. And let me tell you how I'm concerned. You've submitted a reprogramming request, which is what I want to talk about. And that proposal is to transfer $370 million from the medical services account to the medical administration account. You say that it's needed to perfect the distribution of funds between these two accounts as a result of requesting and receiving the 2005 supplemental of $1.5 billion, and the 2006 budget amendment of $1.452 billion, entirely in the medical services account. Both of those came to the medical services account.

Now, what concerns me is that you're transferring this money, but you're not annualizing the cost, and you're saying that it was known at the time that this was going to be done. It was never told to us that this was going to be done, when last year's budget was considered. And this is going to fund salaries in the new account, but, as I understand it, it isn't annualized.

Would you please comment on what impact this is going to have on the delivery of healthcare services? Do we now figure that you're going to be short $370 million for healthcare services? And, also, as you know, one budget affects the other, so does this mean that you're going to need, at some point during the year, an additional $370 million above the President's 2007 figure? Your comments are very important. They're going to be inscribed——

Secretary NICHOLSON. Yes, I—thank you, Senator Feinstein. I hope that I can allay your apprehensions about this, because there should be none. Zero. This will have no impact on the delivery of healthcare. This is an accounting issue.

The Congress authorized us three accounts: a medical—a services account, an administration account, and a facilities account. And we were given money and—through a supplemental. And it was deposited into one account, although the justification that we gave for it was the detail of how we're planning to use the account. But the money was deposited into one account. This is not new, by the way. This has happened in previous years.

Now what we're asking is that we transfer this money, which happens to be in the—I think about 1.2 percent of the total; it's $370 million—into the medical administration account. And that—you're right, that is where we pay the help there. But it was—it is not a diminution of the resources needed for medical services. It was just that it was all put into one account. It would be like if you had, you know, gotten your paycheck into one account, but you use it out of three to run your operations. That's all it is.

Senator FEINSTEIN. Okay. So, it's just going to be an accounting. We will asterisk the record, and hopefully will not have to send it to you later in the year.

MENTAL HEALTH FUNDING

Okay. One of my concerns is that, once again, you may—and I don't know that you are, but you may be underfunding. And if I look at just one thing, veterans patients in fiscal year 2005 and the first 4 months in 2006—these are mental disorders. In 2005, from October 1, 2004 to September 30, 2005, there were 31,860. In 2006, from October 1, 2005 to January 30, 2006—that's just 4 months—you almost reach that number. There's 24,268. My question is—I hope your modeling is dynamic enough to pick up the increase, and do it accurately.

Secretary NICHOLSON. Okay, I—that's a good question, and I'm going to ask Dr. Perlin to give you the detail on it.

Dr. PERLIN. Thank you, Mr. Secretary.

Senator Feinstein, that's a great question. As you know, here we are in 2006, talking about 2007. And, of course, we're using data from the completed year of 2004. And that's the reality of the budget cycle. Now, the model is, as the Secretary said, really a terrific model. It's used by over 100 million—or used to predict the costs of over 100 million beneficiaries, including in all the Blue Cross programs, Aetna, Cigna, public programs, DOD components, Medicaid programs, et cetera. So, it's very good. But obviously there is a lag time inherently. And so, I think what we've tried to say is, with your encouragement, we have the quarterly meetings, so, on top of the model, we superimpose the reality. And, in fact, the mental health budget is, as the Secretary has discussed, extremely robust, $3.2 billion, up $339 million. And, in fact, it actually is not only sufficient to meet the needs of those veterans, but to anticipate even—and improve—services to really the height of world-class service. So, it is a solid budget, but it is the reality on top that's much more dynamic than the model could ever be.

Senator FEINSTEIN. So, in other words, you've corrected the planning model that you had used before that got us into the problems where we were, and you can assure us that there isn't going to be a problem this year, this next year.

Dr. PERLIN. There will not be a problem this year. It's a solid model. And——

Senator FEINSTEIN. Well, this next—the 2007 year.

Dr. PERLIN [continuing]. And as changes—as changes, or if world conditions that can't be foreseen by any of us this moment change, that's the purpose of the quarterly meeting. But we stand by this model, these projections, and our comfort in them is solid.

Senator FEINSTEIN. Okay. I know we have a vote, Madam Chairman. I think that's it for me.

OIF/OEF VETERANS

Why—one last question—why is the VA estimating a decrease of Iraq/Afghanistan veterans in 2007, when the trends suggest you might see more, rather than fewer?

Secretary NICHOLSON. Senator, we've, you know, looked at that carefully. We now have several years of data also to look at. And the—you know, the size of the force is actually diminished in the deployment in the combat zone. That influences that number, as

well. It is diminished by about 11,000 that we're projecting in the 2007 budget from what we're projecting that we will see in 2006.

Senator FEINSTEIN. I have 109,191 in 2007.

Secretary NICHOLSON. Right.

Senator FEINSTEIN. And for the entire fiscal year, VA has estimated we treated a total of 110,556 Iraq and Afghanistan war veterans. Is that wrong?

Secretary NICHOLSON. For 2006?

Senator FEINSTEIN. For the entire fiscal year.

Secretary NICHOLSON. Yeah.

Senator FEINSTEIN. That's this fiscal year, right? Yeah, in this fiscal year, 110,000. You're estimating, for the next fiscal year, 109,000. So, you're cutting it back. Now, you're saying there are fewer troops?

Secretary NICHOLSON. Cutting it back by 1,000.

Senator FEINSTEIN. Right.

Secretary NICHOLSON. Uh-huh.

Senator FEINSTEIN. It's the——

Secretary NICHOLSON. It's based on—you know, we're consulting much closer with DOD on deployments, and it's—you know, it's not materially different. It's about 1,000. The number I gave you before was based on our 2005 experiences.

Senator FEINSTEIN. Well, I hope so. I hope that comes true, that there is not going to be some other event that's going to greatly increase the numbers. But——

Secretary NICHOLSON. Well, I'd like to——

Senator FEINSTEIN [continuing]. I guess my overall——

Secretary NICHOLSON [continuing. Comment on that.

Senator FEINSTEIN [continuing]. Point is that you—even a 12.4 percent increase, you are really closely budgeted.

Secretary NICHOLSON. I would agree with that, Senator Feinstein. And, as I've said, and I would say again, that I think we're doing, you know, an able and a careful job of trying to predict this. But it is a dynamic situation. We are at war. And there are a lot of veterans out there that are eligible for VA care who have not yet, you know, made it available—or taken advantage of it. So, it is dynamic. And that's why I think that we all ought to recognize that this could change, which is why we've instituted these quarterly reviews with the Congress, and a monthly review with the OMB.

Senator FEINSTEIN. Well, I think it'd be very useful—and I'm glad you're doing this quarterly—for us to know, because, you know, post-traumatic stress disorder is only a $5.5 million increase over last year, and I just cross my fingers and hope that this is adequate and that we don't run into the same problem.

So, I thank you very much. And I thank you. The facilities really, I think, are greatly improved in their management and their care and concern, and I very much appreciate that, and——

Secretary NICHOLSON. Thank you.

Senator FEINSTEIN [continuing]. I want you to know that.

Senator HUTCHISON. Secretary Nicholson has asked to leave at 4:30. Obviously, Senator Murray, you just returned. Would you be able to wrap up in 5 minutes? And would you be able to stay, Secretary—Mr. Secretary——

Secretary NICHOLSON. Sure.

Senator HUTCHISON [continuing]. For another 5 minutes or so?

Have you voted already on final passage? I think I'm going to go ahead and leave, if you will wrap up. And just know that he was trying to leave at 4:30, and then end the hearing. I would appreciate it.

Senator MURRAY [continuing]. Your answers, the shorter my time.

Senator HUTCHISON. All right. Thank you.

Senator MURRAY [presiding]. No, I do have a couple of quick issues and really appreciate your bearing with us as we go back and forth on votes.

BELLINGHAM, WASHINGTON

But, Mr. Secretary, I wanted to ask you about the CBOC situation in Bellingham, Washington. We got a white paper—actually sent one to this committee—about evaluating those in the context of fiscal year 2007 budget. If I could just ask you real quick what the timeline is on that, and when can our veterans expect to see progress on the Bellingham CBOC?

Secretary NICHOLSON. Senator Murray, we have that on our list, and we're—we have it under review. But I would be unable to commit to you today when we might do that.

Senator MURRAY. Okay. If I could follow up with you on that, I was home over the recess and got asked about that constantly, so I told my vets I would be seeing you and I would ask the question. So——

Secretary NICHOLSON. We have committed one to—a new one to North Central Washington, as you know.

Senator MURRAY. Right. Right. And I was there, and that's why everybody in Bellingham wanted to know.

TRIBAL MENTAL HEALTH

On tribal veterans, as you know, our tribal veterans have participated in the armed services in a higher per-capita rate than any other minority group. And I met with a number of tribal veterans over the recess, as well, who were very concerned about getting access to culturally relevant services. And I'm especially worried that out in VISN 20 Camp Chapparal, which is a tribal mental health camp—I don't know if you're aware of the services that are there—they're—they've lost half their funding. And they're really disappointed. And many tribal veterans expressed to me that they thought the VA was trying to—had made—actually made a conscious decision to ignore their needs. So, I just wanted to raise that with you. And if we could explore with you how we can make sure that that is funded——

Secretary NICHOLSON. Thank you, Senator. I'm going to ask Dr. Perlin if he'd respond to that.

Dr. PERLIN. Thank you, Senator Murray.

And, as you know, we make a serious commitment. Secretary Nicholson, in fact, in this budget, supports a $339 million increase to bring the mental health budget to $3.2 billion. We take this very seriously. And I've been driving a mental health strategic plan, and we appreciate your support.

I appreciate your bringing that to my attention. I will look into it and we'll be back to you——

[The information follows]

The Veterans Integrated Service Network (VISN) 20 and its predecessor organizations provided funding for a week for Camp Chaparral from 1992 through 2004 for as many as 75 participants each year. Over the years, VA funding climbed from $10,000 to $50,000 per year.

In fiscal year 2005, funding was discontinued for Camp Chaparral due to budgetary concerns and the need to direct all discretionary funding to direct patient care, with an agreement to reconsider funding the Camp in fiscal year 2006. The Yakima Tribe was able to secure funding elsewhere for a smaller version of the Camp and VISN 20 facilities sent 15 participants.

For fiscal year 2006, the Camp is a project that VISN 20 intends to support. Planning for this year's Camp Chaparral is proceeding, and it will be held in August 2006. To adjust for continued budgetary restraints and tight staffing levels, a smaller number of primarily clinical VA staff will attend in a shorter time frame, allowing VA staff to have this valuable experience without an entire week away from their duty stations. VISN 20 staff has been working directly with members of the Yakima Tribe on the planning of this year's Camp.

Senator MURRAY. If you can—if we could have a conversation about that, if you could let me know, because it's an extremely important out there in VISN 20.

Dr. PERLIN. Right.

Senator MURRAY. So, if we could follow up with you on that?

Dr. PERLIN. Absolutely.

Senator MURRAY. Okay.

GULF WAR RESEARCH DATA

I wanted to ask about Gulf War research data, because, at the end of the year, VA is going to reach its deadline for data collection on Gulf War veterans. We are still learning an awful lot about the exposure issues to our veterans from the Gulf War, and I wondered if you would be willing to extend, or eliminate, that deadline so we could continue the data collection.

Secretary NICHOLSON. Well, we, you know, have just committed, and have entered into an agreement with the University of Texas Southwest Medical Center in Dallas, to extend our research endeavors with them. They've had a team of people there working on it for a long time under a Dr. Haley. And that commitment that we have is a 4-year commitment at $15 million a year. I mean, that presupposes that—you know, the approval of that, although we would be able to, I think, manage that within our overall research budget. So, we're very committed to continuing that research.

Senator MURRAY. Okay. Even though the deadline is this year? So, you'd be willing to continue to collect data past this year?

Secretary NICHOLSON. Yeah, the answer is yes. We're very committed—I'm going to ask Dr. Perlin, though, because I may be missing the important point of the deadline.

Dr. PERLIN. Thank you, Senator Murray.

I think one of the things that now exists that didn't exist 10 years ago when we were first looking at how to capture information about Gulf War veterans and their health outcomes was that then one tried to establish a one-off registry. As you've heard a lot of discussion, and we appreciate your support for the electronic health record, but there is no better mechanism for capturing data, not just the facts that are in one registry, but across the entire spec-

trum of whatever the individual comes in with, than the electronic health record. And so, our commitment to understanding the health outcomes of Gulf War veterans will actually be realized in far better ways than we could have envisioned 10 years ago. We use the health record, and you actually generate a cohort of every Gulf——

Senator MURRAY. So, you will——

Dr. PERLIN [continuing]. War veteran.

Senator MURRAY [continuing]. Still be collecting that data, in a—but in a different way?

Dr. PERLIN. We will be collecting data that actually supercedes and augments in the health record.

Senator MURRAY. Okay. I think that's really important, because we're still learning a lot.

Dr. PERLIN. Yes, ma'am.

STANDARDIZING DIABETES MONITORING EQUIPMENT

Senator MURRAY. Let me quickly ask you about the diabetes monitoring issues, the standardization of that. I am hearing a lot of concern from our folks back at home. And I know you were asked by the chairman in the House, but I'm not sure I knew the answer, that, as you know, Congress has reaffirmed its support for the current system on a number of occasions, and most recently in the fiscal year 2006 Military Quality of Life Act. I want to read it to you, because it's important. Section 220 of that bill said, "None of the funds available to the Department of Veterans Affairs in this act or any other act may be used to replace the current system by which the Veterans Integrated Service Networks select and contract for diabetes monitoring supplies and equipment."

As we look at your budget request, I want to take a moment for us—I think it's important to understand—to confirm that the clear congressional direction is not to allow—or not to have standardized diabetes equipment purchases. To your knowledge, in the months that has been passed, has your Department or any of your staff continued to pursue a proposal to standardize diabetes monitoring supplies and equipment?

Secretary NICHOLSON. No.

Senator MURRAY. Well, okay. To your knowledge, no one has been told to do this.

Secretary NICHOLSON. No. The—no.

Senator MURRAY. Okay. Well, it——

Secretary NICHOLSON. Dr. Perlin, you can comment further, if you like.

Dr. PERLIN. Thank you, Mr. Secretary.

Senator Murray, in fact, I think what's worth noting is that the ability to educate veterans well about their diabetes, to achieve benchmark outcomes, as in the TRIAD study, where diabetic patients in VA get better care than in other health systems in the country, comes from some degree of consistency and use. But the concern, as we've understood it, is that no veteran be forced to abandon the equipment they're using, or for us to have a rigid one-device type of activity.

Senator MURRAY. Right.

Dr. PERLIN. So, that guidance, in terms of not transforming from where we are, has been well received and well understood. But I think I would be remiss if I didn't acknowledge that there is some degree of consistency so that there can be consistent training and supplies availability. But we are not——

Senator MURRAY. Well, they are—it has been reported, and I think it's true, that a number of VISN directors still believe that there is direction from your Department, despite congressional attention, to go to a standardized approach. Could you write a letter to each of your VISN directors and tell them that the—reaffirming the current process for selecting diabetes monitoring equipment? And, if you could, if you could provide us with a copy of that correspondence, so we can let them——

Dr. PERLIN. Well, I would like to look into the issue, because there has not been instruction to—instruction has been to follow the precepts of what was provided.

Senator MURRAY. I'm sorry——

Dr. PERLIN. I will be happy to look into the issue.

[The information follows:]

The Department of Veterans Affairs (VA) is not pursuing a proposal to standardize self monitoring blood glucose equipment through a single national contract. Clear communication has been provided to VA Central Office pharmacy program managers and VISN Formulary Leaders regarding the prohibition to pursue standardization contracting. This direction to VA came from the fiscal year 2006 Appropriation Bill, which prohibits VA from expending funds to pursue a national contract.

Dr. PERLIN. To the best of my knowledge——

Senator MURRAY. Okay.

Dr. PERLIN [continuing]. There has not been additional——

Senator MURRAY. Okay.

Dr. PERLIN [continuing]. Standardization.

Senator MURRAY. Okay. If we could have a conversation with you about that, I'd really appreciate it, because I think there is confusion out there on that issue.

VETERANS INTEGRATED SERVICE NETWORK 20

I will just ask one more question. And I know you are over your time limit. But I just want you to know that as a person who represents VISN 20, I am concerned about us being consistently the worst VISN for outcomes in primary and specialty care, and would just like your assurances that you will work with us to try and address this issue. And I'd love to hear your response, maybe in writing, about what we can do to try and get better care out there.

Secretary NICHOLSON. We'd be happy to do that. We have a new VISN director, as you know, and have charged him with, you know, some certain performance expectations for improvement. And we're very hopeful. He's a very capable person. So——

Senator MURRAY. Yeah.

Secretary NICHOLSON. But we'd be happy to discuss it——

Senator MURRAY. Good. I——

Secretary NICHOLSON [continuing]. With you at any time.

[The information follows:]

As of May 5, 2006, VISN 20 has 6,443 veterans waiting for primary care appointments. This is an 11 percent decrease since April 1, 2006, when 7,246 veterans were waiting.

The newly appointed Network Director, Mr. Dennis M. Lewis, FACHE, is providing aggressive leadership to improve access both for primary and specialty Care. In fiscal year 2005 and 2006 to date, he has committed over $31 million to increase operating rooms and intensive care units and medical/surgical beds to rebuild VISN 20's infrastructure and increase inpatient capacity.

In December 2005, each facility director in VISN 20 was assigned as the "champion" of an initiative to address the challenge of increasing access and improving quality. The VISN has now developed strategies for improving performance in clinical measures of care; increasing enrollment in care coordination home tele-health; breaking the cycles of peaks and valleys in specialty care capacity, and fully implementing panel management.

The initiatives are closely monitored for progress, and facility leadership is required to update the VISN on the results of actions taken. In addition, the VISN is tracking the aggressive recruitment and hiring of staff that will also increase capacity. More recently, each facility has been required to implement group clinics by the end of May 2005 to increase capacity and to identify what services patients require. In all of the strategies that have been developed and are being implemented, the Network Director has emphasized that quality care requirements must be paramount in any approach that increases capacity and access.

ADDITIONAL COMMITTEE QUESTIONS

Senator MURRAY. We would all like to understand why it's the case, and what's contributing to that, and make sure we're focused on doing better. So, I appreciate your response.

And thank you very much, Mr. Secretary, Dr. Perlin, and everyone. We really appreciate your patience with all of us.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR KAY BAILEY HUTCHISON

Question. I'm a little concerned the VA is presenting a research budget of $399 million, a 3.16 percent decrease from fiscal year 2006. It is even below the fiscal year 2005 appropriated level. Last year, we asked the VA to place a high priority on Gulf War Illness research, smart limb technology, prosthetics, and other research efforts. This is a time when your research budget should fully fund research and development for advanced medical technologies and prostheses.

Would you please tell us how the VA will meet these research obligations, even though your budget request for research is less than last year's level?

Answer. The Department of Veterans Affairs (VA) is committed to improving the impact of its research program by ensuring that resources are targeted to projects with the highest scientific merit and most relevance to the needs of veterans.

VA is projecting total resources of $1.649 billion in fiscal year 2007 which is an increase of $17 million or 1.1 percent over the 2006 level. These resources consist of $399 million in direct appropriation; $366 million in medical care support funding; $676 million in other Federal grants such as from Department of Defense and the National Institute for Health; and $208 million from private or university funding.

In fiscal year 2007, VA expects to fund about 2,045 direct projects and 2,839 full-time equivalents. In fiscal year 2006 and 2007, the research account no longer pays for its Information Technology (IT) equipment because the central IT Systems appropriation now pays for this type of equipment. The funding which will support IT projects for research is about $15 million in each of these fiscal years. The goals for research are to ensure a balance among the competing needs for meritorious projects, to evaluate and fund existing programs at appropriate levels, and to fund new projects to ensure the advancement of health care for our veterans. Strategies to accomplish these goals include using attrition, transitioning to shorter durations of awards, and conducting competitive reviews of research centers. VA is using performance-based criteria to decide whether to modify, terminate, or expand programs.

For example:

—*Evaluation of Centers of Excellence.*—Centers of Excellence (CoEs) are established only on a competitive basis and their performance is regularly reevaluated through explicit review. In the past year, the Health Services Research and Development Service (HSR&D) closed a HSR&D Center of Excellence because

it was not contributing sufficiently to scientific advances. In addition to freeing $458,000 per year for more productive activities, this action is expected to stimulate increased productivity among other CoEs.

—*Evaluation of Research Enhancement Award Programs.*—The Biomedical Laboratory and Clinical Science Research and Development Services reduced the number of Research Enhancement Award Program (REAP) sites from 34 to 19. This was done to maintain program quality (a REAP application success rate of 25 percent), improve program focus by making REAP awards for study of diseases that are most commonly treated within the VA health care system, and to match resources to those research groups that have contributed most to scientific productivity. The resulting savings of $3.75 million was used to fund an increased number of individual merit review applications.

Clinical Research Productivity.—Developing and implementing small clinical trials within the Medical Research Service was not resulting in larger clinical trials. To address this problem, the Medical Research Service was reorganized into the Biomedical Laboratory and Clinical Science Research and Development Services. The management of small clinical trials was transferred into the Clinical Science Research and Development Service (CSR&D) and the Cooperative Studies Program (CSP) was merged into CSR&D. As a result, the CSP clinical trials planning groups can now assist individual investigators planning small clinical trials. This is expected to significantly increase clinical research productivity.

Question. The Subcommittee feels strongly that the VA establishes specialized medical treatment facilities for mental health and Post Traumatic Stress Disorder as "Centers of Excellence." These centers will allow the VA to consolidate its specialists in personnel, training, and resources to reach the best results for our veterans. For Mental Health/PTSD, in particular, the VA was directed to establish three centers located in the Medical Centers in Waco, Texas; San Diego, California; and Canandaigua, New York.

Please tell us what progress has been made in each of these centers. Are any of these Centers operational?

Answer. While none of these sites are currently operational, the Office of Mental Health Services has been working closely with individuals from Central Texas VA Health Care System (CTVHCS) at WACO and VISN 17; Canandaigua VA Medical Center and VISN 2; and San Diego VA Medical Center and VISN 22 to develop and refine plans for implementing the Centers of Excellence on mental health and Post-Traumatic Stress Disorder. Each of the Centers will include Research and Educational as well as clinical missions to allow them to work toward developing new knowledge and new care providers, as well as to meet current care needs. Each of the Centers will be multifaceted in their activities. Nevertheless, it is possible to summarize their areas of focus: Canandaigua will focus on best practices for treatment of PTSD and other stress-related disorders and for prevention of complications. CTVHCS will focus on both smooth transition from the Armed Forces to the community and the VA and on rehabilitation and recovery. San Diego will focus on the clinical neuroscience underlying the onset of PTSD and related conditions as well as their response to treatment. The implementation of these Centers will proceed in steps with the early selection and funding for leadership and administrative staffing. This will be followed by expedited development and interactive review of the research, educational, and clinical plans, and full funding of the Centers to implement these programs.

Question. The purpose of the CARES program is to systematically renovate and modernize the VA's health care infrastructure and to provide greater access to high-quality care for more veterans. The VA is requesting $399 million for Major Construction, a 52 percent decrease from the budget request level in fiscal year 2006. There are now 17,000 OIF/OEF wounded soldiers, sailors, Marines, airmen, National Guard and Reserve forces requiring medical care.

With many of these many men and women requiring long-term care and rehabilitation, what impact will this increased workload have on the CARES decisions made in 2004?

Does the VA have any plans for a new CARES evaluation or study?

Answer. Since the 2004 CARES decisions were made, VA has modified the VA Enrollee Health Care Projection Model (VAEHCPM) to include OIF/OEF workload projections. This additional workload has been and with each model update will be integrated into decisions regarding the level and types of services OIF/OEF veterans need, including long-term care and rehabilitation services. In light of the enhancements to the VAEHCPM and the emphasis on services to OIF/OEF veterans, we do not anticipate a separate evaluation or study regarding long-term care/rehabilitation services for this group of veterans.

Question. For the Compensation and Pension programs, the VA is requesting $38 billion, $4.1 billion above the fiscal year 2006 level or a 12 percent increase. In fiscal year 2005, the VA's average days pending in rate-related actions was 122; the projections for fiscal year 2006 is 150 and for fiscal year 2007 is 141, with a strategic target of 78.

What efforts will VA make to decrease their claims from 150 in fiscal year 2006 to 141 in fiscal year 2007?

Answer. In the fiscal year 2007 budget submission, VA projected a significant increase in the volume of incoming disability compensation claims as a result of the special outreach mandated in the Military Quality of Life and Veterans Affairs Appropriations Act for 2006. The increased workload is projected to be received in fiscal year 2006 and to continue to impact our pending workload and timeliness of processing into fiscal year 2007. Timeliness of processing is projected to begin to improve toward the end of fiscal year 2007 as these additional claims are processed and the pending claims inventory is returned to more normal levels.

VBA is currently in the process of a major hiring initiative that will add over 850 new employees this year. Our aggressive fiscal year 2006 hiring plan will allow us to enter fiscal year 2007 at or above our requested level for fiscal year 2007 of 13,104 FTE. We anticipate that the training and experience these new employees will receive this year will enable them to have a positive impact on workload reduction efforts in fiscal year 2007, resulting in improved timeliness of processing.

Training for all of our employees continues to be enhanced to ensure they have the necessary skills and tools to perform their duties timely and effectively. An annual core training curriculum for all decision makers is now in place that includes special broadcasts on current issues and training on the more complex aspects of claims processing.

Question. How will you reach your strategic target of 78 average days for claims processing?

Answer. We are continuing to evaluate the feasibility of a 78-day strategic goal for the average age of claims in our pending inventory ("average days pending"). Last year, VA changed the strategic goal for average days to process a rating decision from 100 days to 125 days based on recent changes in the law and in the nature and number of disabilities being claimed that have significantly lengthened the disability decision process. Our review will determine whether a similar change is appropriate in the strategic goal for "average days pending."

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

Question. Since May 2004, when the Capital Asset Realignment for Enhanced Services (CARES) decision was released, PricewaterhouseCoopers' consultants have been working with the VA and the local community to determine the future healthcare facility needs for people living near Louisville, Kentucky. It is my understanding that its report and recommendations have been submitted to the VA.

When do you expect the decision to be made on the future of the Louisville medical facility?

Answer. The Secretary is reviewing and making his decisions concerning Stage I Reports for each study site independent of one another. This will result in multiple announcements in the near future.

Question. Louisville and Lexington, Kentucky's two largest cities are part of VISN 9 which are not scheduled to receive any funding for fiscal year 2007 for constitution projects.

Why is this?

Answer. There are two reasons the Louisville and Lexington VAMCs are not scheduled to receive Minor Construction funding in fiscal year 2007:

—Of the five Minor Construction projects submitted by VISN 9 for fiscal year 2007, one was from a medical center within these two cities—Louisville VAMC. The rest of VISN 9's projects were for the other medical centers within the VISN.

—Louisville's project is a Research project, "Renovate Building 8B for Research." Although Research projects receive approximately 5 percent of the Minor Construction funding, there were 25 Research projects competing for the resources. Based on the anticipated appropriations, this will most likely fund the top two Research projects; Louisville's Research project ranked in the middle of the list.

Question. The CARES study recommends seven Community Based Outpatient Clinics for VISN 15, which includes Daviess, Hopkins, and Graves Counties in Kentucky. Although the budget request includes three projects for VISN 15, none of the fiscal year 2007 funds will be spent on any of the proposed projects in Kentucky.

Please explain why Kentucky is not slated to receive any of the VISN 15 funding for fiscal year 2007.

Answer. The Capital Asset Realignment for Enhanced Services (CARES) study proposed three Community Based Outpatient Clinics (CBOC) for Kentucky that are in the VISN 15 service area. One of the locations, the Hanson CBOC (Hopkins County, KY) was activated in August 2005. The other two CBOCs for Daviess and Graves Counties, KY, remain pending.

Contingent upon funding available in fiscal year 2007, Marion (IL) VAMC will submit a business plan proposal for an additional Kentucky CBOC. Activation will be contingent on VHA review and VA approval.

Question. Does the VA have criteria in place for determining the order in which the recommendations made in the CARES study will be implemented? If so, please provide those criteria to the Committee.

Answer. The VA has a long-standing process to prioritize infrastructure projects. Projects are evaluated against a CARES-specific decision model comprised of the following criteria (in priority order):

—Service Delivery Enhancements (includes realignments)
—Safeguard Assets
—Special Emphasis Programs
—Capital Asset Priorities/Portfolio Goals
—Departmental Alignment
—Financial Priorities

Public Law 108–170, the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, required VA to evaluate projects based on a methodology that prioritizes realignments and safety projects in the first and second priorities. The VA decision model described above has been validated by OMB and Congress as a tool for judging competing needs for scarce capital asset project funds in Agency budget requests to Congress. A more detailed description of the decision criteria can be found in Appendix C of Volume 3, Construction and 5 Year Capital Plan, of the fiscal year 2007 Congressional Budget.

QUESTIONS SUBMITTED BY SENATOR DIANNE FEINSTEIN

Question. The Death Pension is a benefit paid to eligible dependents of deceased wartime veterans. However, it is clear that under the current income eligibility formula, death pension does not meet its original intent of covering the living expenses of dependents of deceased wartime Veterans.

Can you describe the current formula and income eligibility levels that are now employed to determine whether a dependent of a deceased wartime Veteran may receive compensation through the VA?

Answer. Under the provisions of Public Law 95–588, VA's Improved Pension is an income maintenance program designed to assure a level of income to wartime veterans and their survivors. To be eligible, a claimant may not have income countable for VA purposes that exceeds the yearly income limit (maximum annual pension rate) shown in the chart below. The maximum pension rate is higher for veterans than for survivors.

The claimant's countable income determines the amount of VA benefits paid. There is a dollar-for-dollar reduction from the maximum rate for all income received by a claimant (excluding other needs-based program payments such as SSI or welfare). Medical expenses that exceed 5 percent of the maximum annual pension rate and for which the claimant is not reimbursed are deducted from the claimant's countable income to increase the amount of pension payable. The monthly rate payable is calculated by subtracting the claimant's countable annual income from the maximum annual pension rate and dividing the difference by 12.

Death Pension	Maximum Annual Pension Rate (as of 12/1/05)	Minimum Monthly Payment	Maximum Monthly Payment
Surviving Spouse—Without Dependents	$7,094	$1	$591
Surviving Spouse—With One Dependent	9,287	1	774
Surviving Spouse Aid & Attendance—Without Dependents	11,340	1	945
Surviving Spouse Aid & Attendance—With One Dependent	13,529	1	1,127
Surviving Spouse Housebound—Without Dependents	8,670	1	723
Surviving Spouse Housebound—With One Dependent	10,860	1	905
Child Only	1,806	1	151

Question. What do you believe would be a more acceptable and appropriate yearly income threshold that would ensure that low-income dependents of wartime Veterans receive adequate compensation through death pension benefits?

Answer. In December 2004, the Evaluation of the VA Pension Program concluded that survivors receiving pension are worse off, on average, than similarly situated low-income female and elderly Americans. On the other hand, veterans receiving pension were found to be generally better off than their peers. According to the report, this situation exists because veterans are eligible to enroll in VA healthcare, whereas survivors are not. Consequently, very few veterans in receipt of pension are also receiving Medicaid or SSI benefits. A much larger number of survivors, more than 40 percent, receive SSI and Medicaid.

VA has not determined what, if any, changes should be made to the income threshold for the death pension program. It is possible that raising the maximum annual pension rate for survivors, especially those not entitled to Medicare, could jeopardize their continued eligibility for Medicaid. An increase in the death pension rate could potentially worsen some pension beneficiaries' overall financial position due to the loss of healthcare coverage. We believe that any proposal being considered by Congress to raise the income limit for death pension eligibility should take this factor into consideration.

Question. Does VA have any plans to alter the current income threshold and eligibility formula to better provide for the needs of dependents of wartime Veterans through the death benefits program?

Answer. Legislation would be required to change the current income threshold and eligibility formula for the death pension program. VA does not have any current plans to propose legislative changes to the death pension program.

QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

Question. I would like to ask you a question regarding the New Orleans VA Medical Center. In the House of Representatives' passed version of the Hurricanes of the Gulf Coast Supplemental #4, $550 million was appropriated to reconstruct the New Orleans VA Medical Center. Included in this appropriation was language allowing you to transfer up to $275 million to the VA Medical Services account for unanticipated medical costs of returning veterans fighting the Global War on Terror.

Do you support the inclusion of this language?

Answer. VA appreciates the House action in this matter; however, VA does not expect to utilize this authority for either the remainder of fiscal year 2006 or fiscal year 2007 for the medical costs of returning veterans fighting the Global War on Terror because these requirements are already funded in the fiscal year 2006 and proposed fiscal year 2007 budgets. VA needs the referenced funds to construct a new medical facility for New Orleans to replace the one severely damaged by the Hurricanes last year.

Question. Is this a warning sign that maybe the VA has miscalculated funding needs, yet again, and will need additional money to cover the unanticipated medical costs of returning Global War on Terror veterans?

Answer. The President's amendment to the fiscal year 2006 budget request provided an additional $1.977 billion for the current fiscal year. These resources will enable VA to continue to provide the high-quality health care to our Nation's veterans. The President's 2007 request includes total budgetary resources of $34.3 billion for the medical care program, an increase of 11.3 percent (or $3.5 billion) over the level for 2006 and 69.1 percent higher than the funding available at the beginning of the Bush Administration. The cornerstone of our medical care budget is providing care for veterans who need us the most—veterans with service-connected disabilities; those with lower incomes; and veterans with special health care needs. A key element of this effort is to make sure every seriously injured or ill serviceman or woman returning from combat in Operation Enduring Freedom and Operation Iraqi Freedom receives priority consideration and treatment. These resources will enable VA to continue to provide the high-quality health care to our Nation's veterans.

Question. If this money is transferred, it is a sure possibility this will prevent the final completion on the rebuilding of the new New Orleans VA Medical Center.

If this is happens, how would the VA plan on funding the completion of the hospital?

Answer. As previously stated, VA needs these funds for the construction of a new medical center for New Orleans.

Question. Would you replace the funds in the VA's annual appropriations budge?

Answer. Again, VA does not expect a need to do this. The entire $561 million will be required to rebuild the New Orleans VA Medical Center.

Question. Many concerns regarding mental health stem from nondisclosure by Service members. This nondisclosure has the potential to disrupt early intervention and see an underestimation of future demand for VA mental health services.

With an ever-growing focus on mental health, in your estimation, how well-equipped is the VA to deal with this problem?

Answer. In terms of capacity to provide mental health services to those who do disclose problems, I have reviewed the capability of the Veterans Health Administration (VHA) to meet the needs for inpatient and outpatient Post-Traumatic Stress Disorder (PTSD) diagnosis and treatment as well as diagnosis and treatment of other mental health and substance abuse concerns of veterans. This review has included monitoring on a quarterly basis the mental health diagnosis and treatment needs of recently discharged service members from Operation Iraqi Freedom and Operation Enduring Freedom. I have found that VHA has adequate capabilities to serve their needs.

In anticipation of any unmet needs or capabilities, VHA identified significant additional resources in fiscal year 2005 and fiscal year 2006 in a variety of mental health programs, including specialized PTSD and Readjustment Counseling Center programs to supplement current services. Since PTSD often coexists with substance abuse disorder, depression, and homelessness, VA supplemented programs in those areas in fiscal year 2005 and fiscal year 2006. In fiscal year 2005, new and enhanced PTSD programs received funding of $9,953,186, and a new class of programs specifically designed for early identification and care for returning veterans (Returning Veterans Outreach Education and Care (RVOEC) programs were provided funded of $6,676,312. In addition, in fiscal year 2005, $7,987, 505 was provided for substance use disorder treatment programs; $8,249,348 was provided for Homeless Domiciliary programs; and $4,500,000 was provided for homeless grant and per diem programs. In fiscal year 2006, $10,865,874 will be provided for new/enhanced PTSD programs; $6,932,646 will be used for new RVOEC programs; and $16,651,698 will be spent on substance use disorder treatment programs. Readjustment Counseling Service hiring of counselors who are veterans of the Global War on Terror will be provided up to $1,100,000 in fiscal year 2006.

Your question also addresses a more subtle issue, which is how to encourage self-disclosure of mental health concerns on the part of returning service members and veterans. You are correct that our system can only provide services when individuals do self-disclose and then can be guided in terms of how the system can best respond to the problems they are experiencing. There are several issues embedded within this overall concern. Generally, there are three major issues we can address: efforts to destigmatize mental health problems; efforts to help veterans progress in terms of readiness to change; and efforts to educate veterans and their families about resources available if they do self-disclose.

First, concerning destigmatization, the Mental Health Strategic Plan, which is based in large part on the President's New Freedom Commission on Mental Health report as adapted for VA, suggests a wide array of activities to combat stigma in relation to mental health. Many of these have already been completed, including various educational efforts with VA staff. Ultimately, it is the larger society that needs to change in terms of reducing the stigma of mental health problems, but VA is committed to taking a leading role in that effort. VA also supports the efforts of the Department of Defense to deal with this issue in relation to active service members.

Second, there is a large and important literature on the importance of understanding and respecting the process of becoming ready to seek help and change for mental health problems. Individuals progress from an early period of unawareness of and inability to identify developing concerns through stages to a point of readiness to engage in action to change the problem. It is important to match clinical services provided to this level of readiness in order to accomplish optimal outcomes. We have designed our programs to follow that natural progression, with outreach and educational efforts designed to help those who are earlier in the process and a variety of active clinical programs, as described in the opening paragraphs, for those who are ready to act and receive clinical care for their mental health concerns.

Third, veterans may fail to self-disclose problems if they are not aware of the availability of services to meet their needs. Understanding this, we have developed the new class of programs described above, the Returning Veterans Outreach Education and Care (RVOEC) programs. These are specifically designed to meet the needs of newly returning veterans. As the title suggests, efforts are made to do outreach to identify such veterans, to educate them about available mental health services and the process of accessing these services, and to be supportive and contribute

to destigmatization by normalizing adjustment concerns veterans may have. Similar efforts are made through the Veterans Readjustment Counseling programs; the RVOEC teams work with and through medical facilities so that such services are available to veterans throughout the system. These and other efforts ultimately are designed to teach veterans, their families, and the community at large that effective treatments are available for PTSD, depression, and other stress-related conditions and that VA has the ability to offer those treatments to them, if they present themselves for care. Ultimately, veterans are more likely to self-disclose if they know that their concerns will be handled respectfully, sensitively, and by offering appropriate, effective treatment.

Question. Last year the Administration proposed to restrict per diem payments to only a small fraction of veterans living in State Homes and placed a moratorium on construction grants. As you also know, Congress restored construction grant funding to $85 million last year. However, this was almost a $20 million cut from fiscal year 2005 levels. Although, the fiscal year 2007 budget request did not repeat these ill-advised proposals, the construction grant request was only for $85 million. It has been expressed to me, by the National Association of State Veterans Homes, that although $85 million is better than $0 funding, they wish to see the budget restored back to $104.3 million.

Did you consult with the National Association of State Veterans Homes before you submitted your request for the fiscal year 2007 budget?

Answer. VA program staff regularly participates in the bi-annual national meetings of National Association of State Veterans Homes (NAVSH), and the Secretary has met with the organization's executive leadership. NAVSH interests and concerns are well known to VA through these continuing interactions.

Question. How many construction grants will be given with this $85 million, how many Homes will see a piece of the $85 million?

Answer. It is not possible to predict how many construction grants will be given until: (1) the fiscal year 2007 Priority List is finalized and approved in September 2006; (2) the final price of the projects in Priority Group 1 is determined; and (3) the amount of carryover of fiscal year 2006 funds, if any, is established.

Question. How will the construction of the new State Home in California affect availability of funds to award other contracts? How will it affect the repairs and such at other State Homes?

Answer. Under the current regulations, VA's conditional award of a grant for the construction of the new State home in California before the end of this fiscal year would preclude the award of any other construction grants in fiscal year 2007 except those that are conditionally awarded a grant this fiscal year.

Question. State Veterans Homes are critical to the healthcare needs of veterans throughout the United States. As critical as State Veterans Homes have been in my State, I have worked hard to insure the proper fiscal attention is given them.

Do you share the critical need for State Homes and, if so, do you agree that Congress should mandate new consultation and reporting requirements for VA prior to the implementation of any proposed changes to the current per diem system?

Answer. State Veterans Homes are an important option for veterans in considering their health care needs. We do not agree that Congress should mandate new consultation and reporting requirements for VA. VA consults extensively with individual State homes, with the National Association of State Veterans Homes (NASVH), and with the National Association of State Directors of Veterans Affairs (NASDVA) and provides relevant information regarding State Veterans Home programs to all of those stakeholders when it is cleared for public release.

Question. Blinded Veterans have limited mobility and, oftentimes, insufficient infrastructure to deal with their specific needs. There are only 10 VA Blind Rehabilitation Centers across the country with a waiting list that causes an average waiting time of more than 9 weeks.

How is the VA working to improve the efficiency and availability of care for blind veterans?

Answer. VA Blind Rehabilitation Service is making significant improvements in both the efficiency and availability of care for blinded veterans. The VA Blind Rehabilitation Service Program Office, in conjunction with the Visual Impairment Advisory Board, has developed a continuum of care model. This model is designed to ensure that the visual needs of veterans are addressed throughout the progression of the vision loss in settings most convenient to the patient. When possible, services are provided in the veteran's local community. The inpatient Blind Rehabilitation Centers will continue to provide advanced rehabilitation services. The intensity of the intervention is tailored to the complexity of the patient's needs and additional services at the next level of care can be provided as the patient's vision rehabilita-

tion needs increase. Placement of the services will be determined by patient demographics.

Under the CARES planning process, two Blind Rehabilitation Centers at Biloxi and Long Beach will be created. In addition, Cleveland VAMC is adding a new Center. The new Centers will significantly reduce waiting times and service patients in those demographic areas.

To further reduce waiting times for admission to a Blind Rehabilitation Center, Blind Rehabilitation Service developed a community-based Computer Access Training program to augment the inpatient Computer Access Training that is provided in the Blind Rehabilitation Centers. In this program, local service providers teach Computer Access Training to veterans in their home area, where feasible. Locally provided Computer Access Training has proven to be a cost effective alternative, which reduced waiting, increased access, and benefited blinded veterans.

Blind Rehabilitation Service has expanded services to blinded veterans in their local communities with the establishment of Blind Rehabilitation Outpatient Specialist (BROS) positions at VA medical centers. There are now 28 BROS positions.

Since initiating these efforts, the waiting times for admission to an inpatient Blind Rehabilitation Center have decreased 37 percent from fiscal year 2004 through fiscal year 2005. Waiting times for admission to a Blind Rehabilitation Center Computer Access Training program decreased 23 percent for the same time period.

The VA Blind Rehabilitation Service Program Office is working with the Information Technology Office to develop a new national database to monitor all aspects of blind rehabilitation service delivery including waiting times. The anticipated release date is during the fall of 2006. This database will increase the efficiency of patient care for blinded veterans.

SUBCOMMITTEE RECESS

Senator MURRAY. This Subcommittee is recessed.

[Whereupon, at 4:38 p.m., Wednesday, March 29, the subcommittee was recessed, to reconvene subject to the call of the Chair.]